

HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
JUNE 26, 2013
APPLICATION SUMMARY

NAME OF PROJECT: Tri-Cities Holdings, LLC d/b/a Trex Treatment Center

PROJECT NUMBER: CN1302-005

ADDRESS: 4 Wesley Court
Johnson City (Washington County), Tennessee 37601

LEGAL OWNER: Tri-Cities Holdings, LLC
6555 Sugarloaf Parkway, Suite 307-137
Duluth (Gwinnett County), Georgia 30097

OPERATING ENTITY: Not Applicable

CONTACT PERSON: Steven W. Kester
(404) 664-2616

DATE FILED: March 8, 2013

PROJECT COST: \$670,000.00

FINANCING: Cash Reserves of Kester L.P.

PURPOSE OF REVIEW: Establishment of a nonresidential substitution-based treatment center for opiate addiction and the initiation of opiate addiction treatment

DESCRIPTION:

Trex Treatment Center is seeking approval to establish a nonresidential substitution-based treatment center that provides opiate addiction treatment (referred to as OTP for opiate treatment program throughout the remainder of the report). The OTP will provide individual counseling and group therapy and will offer methadone and buprenorphine to prevent symptoms of withdrawal. The service area includes Carter, Cocke, Greene, Hamblen, Hawkins, Johnson, Sullivan, Unicoi and Washington counties. The OTP will operate as a private, for-profit clinic under all applicable licensure requirements of the Tennessee

Tri-Cities Holdings, Inc.

CN1302-005

June 26, 2013

PAGE 1

Department of Mental Health and Substance Abuse Services (TDMHSAS). No state, federal, or local funding will be sought.

**SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW:
NON-RESIDENTIAL METHADONE TREATMENT FACILITIES (NRMTF)***

A non-residential narcotic treatment facility should provide adequate medical, counseling, vocational, educational, mental health assessment, and social services to patients enrolled in the opioid treatment program with the goal of the individual becoming free of opioid dependency.

The applicant reports that patients will receive continuous and intensive counseling, services, and mental health assessments aimed at helping the patient become free of opioid dependency. This includes educational services delivered through counseling staff and referrals to vocational services. Patients will be supervised by a Board-Certified physician experienced in opioid dependency per TDMHSAS Rules. The applicant projects 530 patients in Year 1 while employing twelve (12) substance abuse counselors. The applicant indicates the industry standards dictate a client-to-counselor ratio of 50 to 1.

The TDMHSAS Report (page 17) indicates the application does not have enough information to determine whether staffing requirements will be met and if staff will have the appropriate certifications.

It is unknown whether this criterion has been met.

Need

The need for non-residential narcotic treatment facilities should be based on information prepared by the applicant for a certificate of need, which acknowledges the importance of considering the demand for services along with need and addressing and analyzing service problems as well.

The assessment should cover the proposed service area and include the utilization of existing service providers, scope of services provided, patient origin, and patient mix.

The assessment should consider that the users of opiate drugs are the clients at non-residential narcotic treatment facilities, and because of the illegal nature of opiate drug use, data will be based on estimates, actual counts, arrests for drug use, and hospital admittance for drug abuse.

Tri-Cities Holdings, Inc.

CN1302-005

June 26, 2013

PAGE 2

The assessment should also include:

1. **A description of the geographic area to be served by the program;**

*The applicant proposes to serve eligible individuals residing in a nine county service area, which includes Carter, Cocke, Greene, Hamblen, Hawkins, Johnson, Sullivan, Unicoi, and Washington counties. The applicant further defined the service area by using a 2002 report** that included Methadone Service Areas (MSA). This information is included on pages 118-121 of the 1st (March 25, 2013) supplemental application.*

It appears that this criterion has been met.

2. **Population of area to be served;**

The population of the proposed service area in 2013 was 600,895.

The estimated number of persons, in the described area, addicted to heroin or other opioid drugs and an explanation of the basis of the estimate;

The applicant estimates there are between 12,000 and 24,000 adults who are addicted to opiates (heroin and prescription pain pills) in the proposed nine (9) county service area. The applicant calculated the estimates from SAMSHA (Substance Abuse and Mental Health Services Administration) and TDMHSAS reports.

The TDMHSAS Report questions the applicant's need methodology and indicates it has resulted in a misrepresentation.

It appears that this criterion has not been met.

3. **The estimated number of persons, in the described area, addicted to heroin or other opioid drugs presently under treatment in methadone and other treatment programs;**

TDMHSAS Central Registry data related to opioid treatment is no longer available to the Health Services and Development Agency. According to a representative of the TDMHSAS, the sole function of a central registry is to prevent multiple enrollments of individuals receiving methadone treatment. Further, any information disclosed to a central registry may not be used for any other purpose than the prevention of multiple enrollments, unless directed by a court order. TDMHSAS concluded that this language prevents the contents of the Central Registry being used to obtain utilization data.

Since current data is not available, the applicant based its estimates on

Tri-Cities Holdings, Inc.

CN1302-005

June 26, 2013

PAGE 3

previously released 2008 Central Registry data, and a telephone survey.

The 2008 Central Registry data indicated 175 patients in the nine county service area received treatment from a Tennessee-based methadone maintenance provider. The applicant calculated that 866 patients in the proposed service area now need treatment by applying 2008 Central Registry data to population data (see page 19 of the 1st supplemental).

The applicant estimated 950-1,500 people receive treatment for opioid dependency from clinics in Knoxville, Tennessee and Asheville and Boone, North Carolina. The methodology for the estimate is based on telephone interviews and the Applicant's "own data and extrapolation." The methodology is detailed on pages 19 and 20 of the March 25, 2013 supplemental application.

The TDMHSAS Report questions the applicant's need methodology.

Since current data is not available, staff contacted the Virginia and North Carolina Methadone Authorities in early June 2013. Virginia estimated as many as 50 Tennessee residents were crossing the state line into Virginia for treatment. North Carolina has indicated it will respond prior to the June 26 Agency meeting.

While this criterion does require the applicant to "estimate the number of persons addicted to heroin or other opioid drugs presently under treatment...." this estimate relies on 2008 Tennessee Department of Mental Health Registry data and on secondary sources which have not been verified.

It is unknown whether this criterion has been met.

4. Projected rate of intake and factors controlling intake;

The applicant projects the rate of intake will be 50 patients per week.

5. Compare estimated need to existing capacity.

There are 77 SAMSHA certified buprenorphine (suboxone) outpatient providers in the proposed service area. There are no existing OTPs in the service area.

Also, consideration should be given to the reality that existing facilities can expand or reduce their capacity to maintain or treat patients without large changes in overhead.

There are no existing OTPs in the service area. Migration data of patients who travel outside of the proposed service area is not available.

It appears that this criterion is not applicable.

Tri-Cities Holdings, Inc.

CN1302-005

June 26, 2013

PAGE 4

Service Area

The geographic service area should be reasonable and based on an optimal balance between population density and service proximity.

There are no OTPs in the applicant's proposed service area.

It appears that this criterion has been met.

The relationship of the socio-demographics of the service area and the projected population to receive services should be considered. The proposal's sensitivity to and the responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, and low-income groups.

The applicant states a U.S. Center for Disease Control (CDC) report states opioid abuse and overdose cuts across all genders, age groups, race, and economics. The TDMHSAS report (page 9) indicates the cited CDC reference cannot be confirmed.

The applicant references the Appalachian Commission Report of 2008. The TDMHSAS Report (page 11) questions whether this study can be appropriately applied to the proposed service area.

The program will be accessible to a few people in the low-income group. Charity care will be provided at the rate of approximately 2.0% of total gross revenue in Years 1 and 2 (\$35,643 or approximately 11 patients and \$78,074 or 21 patients, respectively).

Since a small percentage of charity care will be provided, it appears that the program may be accessible to a few people in the low-income group. It appears that this criterion may be partially met.

Relationship to Existing Applicable Plans

The proposals' estimate of the number of patients to be treated, anticipated revenue from the proposed project, and the program funding source with description of the organizational structure of the program delineating the person(s) responsible for the program, should be considered.

The applicant proposes to provide services to 530 patients in 2014 generating gross operating revenues of \$1,782,144. Treatment is self-funded by the patient. The applicant has provided an organizational structure of the

Tri-Cities Holdings, Inc.

CN1302-005

June 26, 2013

PAGE 5

program and person responsible for the program.

According to the SAMSHA Alcohol and Drug Services Study (ADSS) titled "The National Treatment System: Outpatient Methadone Facilities", March 2004, Private for-profit outpatient methadone facilities were much less dependent on public revenue than other facilities. Seventy-nine percent of private for-profit facilities received less than half of their revenue from public sources.

It appears that this criterion has been met.

The proposals' relationship to policy as formulated in local and national plans, including need methodologies, should be considered.

There appears to be no local or national plans that include needs methodologies.

It appears that this criterion is not applicable.

The proposals' relationship to underserved geographic areas and underserved population groups, as identified in local plans and other documents, should be a significant consideration.

In June 1999, the Washington County Health Council developed plans to address priority health concerns. Adult Alcohol/Drug Abuse was ranked as the 3rd highest area of concern for Washington County as based on the following: (a) the size of population impacted, (b) the seriousness of health concern both present and future, and (c) the effectiveness of potential interventions. Source: The Washington County Health Council Report 1999.

The report did not specifically address nonresidential substitution-based opioid treatment programs.

It appears this criterion is not applicable.

The impact of the proposal on similar services supported by state appropriations should be assessed and considered.

The applicant plans to utilize self-pay programs and does not plan to participate in State and Federal programs such as TennCare or Medicare.

It appears that this criterion is not applicable

Tri-Cities Holdings, Inc.

CN1302-005

June 26, 2013

PAGE 6

The degree of projected financial participation in the Medicare and TennCare programs should be considered.

The applicant plans to utilize self-pay programs and does not plan to participate in State and Federal programs such as TennCare or Medicare.

It appears that this criterion is not applicable

** Note to Agency Members: The criteria and standards for certificate of need have not been updated to reflect the change in nomenclature to nonresidential substitution-based treatment center for opiate addiction. The Non-Residential Methadone Treatment Facilities (NRMTF) standards were included in the 2000 Edition of the Guidelines for Growth. The Division of Health Planning has had preliminary discussions with TDMHSAS regarding the development of new standards and criteria.*

***The applicant is referring to a report generated in response to Public Chapter 363 of the Acts of the 2001. The legislation directed the Commissioner of Health to study issues relating to the need for and location of non-residential methadone treatment facilities in the Certificate of Need process. The legislation directed the Commissioner to consult with the Health Facilities Commission and the Board for Licensing Health Care Facilities to design precise guidelines concerning the location of new non-residential methadone treatment facilities and the need for any additional regulation of non-residential methadone treatment facilities. The legislation also directed the Commissioner to report recommendations to the house health and human resources committee and the senate general welfare, health and human resources committee on or before January 1, 2002. The Commissioner assembled a task force, which proposed recommendations for changes to the rules of the Board for Licensing Health Care Facilities that govern methadone treatment facilities as well as modifications to the Guidelines for Growth. The goal was to provide assistance in making decisions about the need for and location of methadone facilities in the state. Information from the state's Central Registry of methadone patients in treatment was compiled, analyzed, and studied by the task force.*

The report designated 23 distinct Methadone Service Areas (MSA) within the state to assure reasonable patient access to a methadone program. MSA was defined as a county or constellation of contiguous counties in the state that comprise a sufficient general population making it likely that a minimum number of opiate dependent persons reside in the MSA who seek treatment could support a program. The minimum population foundation was balanced with the need to establish geographic boundaries such that patients living within the MSA would reside within an hour drive one-way to a treatment program if the program were established in the heart of the MSA.

A copy of the Report is attached to this summary.

Staff could find no evidence that the General Assembly or any state agency adopted any of the findings. TDH did revise rules related Non-Residential Narcotic

Tri-Cities Holdings, Inc.

CN1302-005

June 26, 2013

PAGE 7

Treatment Facilities, effective May 4, 2003. There were no changes to the Guidelines for Growth. Executive Order 44, dated February 23, 2007, transferred the regulation of all Alcohol & Drug facilities back to the Department of Mental Health.

SUMMARY:

Tri-Cities Holdings, LLC d/b/a Trex Treatment Center is an active limited liability company registered with the Tennessee Secretary of State. It was formed on January 11, 2013 with two members holding 50% membership each: Steve Kester and Leigh B. Dunlap. Steve Kester serves as the Chief Executive Officer.

A brief summary of the management biographies of the owners (March 25, 2013 supplemental/page 49) follows: Steve Kester is the co-founder of Treatment Centers HoldCo d/b/a Crossroads Treatment Centers. He is currently a minority shareholder of Treatment Centers HoldCo and is not active in the management of the company. Treatment Centers HoldCo operates 3 methadone treatment centers in North Carolina, 3 in South Carolina, 2 in Georgia and 1 in Virginia. Leigh B. Dunlap has no healthcare experience. She is identified as a "unit holder" and has no management position in the company.

The proposed facility will be located on 1.66 acres in an 8,260 square feet facility at 4 Wesley Court, Johnson City (Washington County). This location is an industrial area zoned for medical services. The applicant holds an Option to Lease agreement with an initial term of 5 years with an option to renew for two additional 5-year terms (for a total of 10 additional years). The monthly lease is \$5,440. The applicant indicates the size of the facility and accompanying parking can accommodate 1,000 patients with a one-shift operation.

The applicant provided a copy of the Johnson City Zoning Regulations specific to methadone clinics in the March 25, 2013 (page 109) supplemental response. The applicant does not comply with zoning regulation 6.13.3.4, items E. and F. (below), has requested a zoning variance, and has challenged the denial by Johnson City in Federal Court (such litigation is ongoing).

6.13.3.4 Methadone Treatment Clinic provided:

E. The hours of operation shall be between 7:00 am and 8:00 p.m.

The applicant plans to operate from 5:00 A.M. until noon seven days a week. The applicant states a majority of the traffic at the proposed facility is expected between 5:00 A.M. and 7:00 A.M. so patients can get to work and school.

Tri-Cities Holdings, Inc.

CN1302-005

June 26, 2013

PAGE 8

Note to Agency Members: The TDMHSAS Map of the 12 existing Tennessee Statewide Opioid Treatment Centers indicate 5 centers open at 5:00 A.M., 5 at 5:30 A.M., 1 at 5:45 A.M., and 1 at 6:00 A.M.

- F. The facility shall be located on and the primary access shall be from an arterial street.

The applicant states the facility is located on a cul-de-sac with industrial and commercial customers nearby (construction supply company, a construction company, and an empty lot).

The total population of the nine county primary service area (PSA) is estimated at 600,895 residents in calendar year (CY) 2013 increasing by approximately 1.7% to 610,962 residents in CY 2017. The applicant states the proposed service area represents Washington, Carter, Johnson and Unicoi counties in Methadone Service Area #1, Sullivan and Hawkins counties in MSA #2, and Greene, Cocke and Hamblen counties in MSA #3.

There are currently no other licensed facilities in the proposed service area. If approved, Tri-Cities Holdings, Inc. will be the 13th OTP in the state (note: a map of all licensed and proposed OTPs is provided with this summary). The closest treatment facilities in the state are located in Knoxville (Knox County), TN.

Behavioral Health Group (BHG) based in Dallas, Texas currently owns a majority of the existing methadone clinics (nine of the twelve) in Tennessee. BHG owns clinics in Knoxville (2), Nashville (1), Memphis (3), Jackson (1), Paris (1), and Columbia (1). BHG also owns 29 other facilities in Colorado, Kansas, Kentucky, Louisiana, and Texas.

Since TDMHSAS Central Registry Opioid Treatment data is no longer available, staff has attempted to pull together historical information for Agency members.

Paris Professional Associates, CN0903-014A, reviewed in 2009, was the last methadone application that included methadone registry data. The applicant provided a copy of the 2008 Methadone Registry that indicates consumers by county of residence and clinic. A copy of the 2008 registry is located on the March 25, 2013 supplemental pages 110B-110G. This registry captured only the Tennessee facilities where methadone patients receive services. The methadone registries of adjoining states were not available.

The following table displays the 2008 service area out-migration for the nine-county service area to Tennessee OTPs:

**2008 Methadone Registry
Proposed Service Area Out-Migration**

County	Treatment Facility				Total
	Davidson County- MidSouth TX Ctr.	Hamilton County- Volunteer TX Ctr.	Knox DRD Knoxville- Location #1	Knox DRD Knoxville,- Location #2	
Carter		4	2	1	7
Cocke		1	10	12	23
Greene			2	8	10
Hamblen		14	38	31	83
Hawkins	1	2	5	15	23
Johnson	1		1		2
Sullivan	1		10	8	19
Unicoi		1		1	2
Washington			4	2	6
Total	3	22	72	78	175

Source: CN1302-005

According to the TDMHSAS Tennessee Opioid Treatment Clinics Map, the hours of operation of Knoxville clinics are Mon-Sat, 5:30 A.M.-2:30 P.M. with dosing hours between 5:30 A.M.-11:00 A.M. and Saturday between 6:00 A.M. to 9:00 A.M.

Source: http://www.tennessee.gov/mental/A&D/A_D_docs/methadonelabeledclinics.pdf

The applicant states patients must attend every day (seven days a week) for the first 45 days of treatment before being permitted to take the drugs off-site.

The 2001 Methadone Task Report indicated the number of people seeking treatment for opiate addiction was directly proportional to the distance traveled to receive treatment. The Task Force report also noted the number of patients diminish greatly when the distance lived from the clinic exceeds 60 miles. The following is a table of driving distances and driving time for methadone services from larger cities in the proposed service area to the proposed clinic in Johnson City, TN and the nearest existing clinics located in Knoxville, TN and Weaverville, NC.

Tri-Cities Holdings, Inc.

CN1302-005

June 26, 2013

PAGE 10

The closest Tennessee OTP is located in Knoxville (Knox County), Tennessee which is located over 100 miles away or approximately 1 hour and 45 minute drive time from the cities of Johnson City, Bristol, and Kingsport in the proposed service area. The closest out of state OTP is located in Weaverville, NC with a traveling distance of 52 miles/56 minutes for residents of Johnson City, TN.

Methadone Provider	Johnson City, TN (Washington Co.)	Kingsport, TN (Sullivan Co.)	Bristol, TN (Sullivan Co.)
Proposed Tri-Cities Holdings, Inc., Johnson City, TN	0	21 miles/28 min.	22 miles/36 min.
Crossroads of Weaverville, Weaverville, NC	52 miles/56 min.	74 miles/1 hr. 23 min. min.	76 miles/1hr.32 min.
DRD Knoxville Medical Clinic- 2 locations, Knoxville, TN	106.5 miles/1 hr. 43 min.	102 miles/1 hr. 42 min.	112 miles/1 hr. 47 min.

Source: MapQuest

The applicant proposes to serve 530 clients in Year 1 increasing to 1,056 clients in Year 2. Of the 530 patients served during the first year, the applicant projects to serve 387 methadone patients or 73%, 133 buprenorphine-based treatment patients or 25%, and 10 or 2% abstinence-based treatment patients.

The fee schedule is on page 37 of the March 25, 2013 supplemental information. A failed drug screen results in a charge of \$25.00. The applicant indicates the buprenorphine daily dosage fee for TennCare members would be adjusted if TennCare pays for the prescription.

The applicant reports methadone maintenance treatment (MMT) was developed in 1964 and is the most common and established form of opioid addiction treatment. In October 2002, the applicant notes the Food and Drug Administration (FDA) approved buprenorphine, subutex, and suboxone for use in opioid addiction treatment. The applicant states the greatest difference between the two is that buprenorphine is a partial opiate agonist but methadone is a full opiate agonist. The applicant indicates private physicians rarely offer counseling in conjunction to buprenorphine treatment and states getting buprenorphine from a physician's office is termed "dose and dash" because of the lack of counseling, drug testing, diversion monitoring and care planning. The applicant notes the following differences between buprenorphine and methadone:

Tri-Cities Holdings, Inc.

CN1302-005

June 26, 2013

PAGE 11

- Buprenorphine is harder to abuse so patients are allowed to take it home. Methadone can be more easily abused, when patients first start treatment they need to travel to a clinic each day to take their dosage. At later stages of treatment, patients are allowed take-home doses of methadone.
- For people with heavy opiate habits and serious addiction, buprenorphine cannot provide effective relief from withdrawal symptoms. Methadone works better for such individuals.
- Buprenorphine is generally less addictive than methadone.
- Withdrawal symptoms of a buprenorphine detox are generally less severe than methadone detox, and
- The risk of fatal overdose on buprenorphine is less than the methadone.

The applicant states the OTP plans to utilize self-pay programs and does not plan to participate in Medicare or TennCare. Effective August 1, 2005 TennCare no longer provided coverage for methadone maintenance services for adult TennCare enrollees. According to the TennCare Quick Guide dated May 2013, Methadone Maintenance Treatment is covered as medically necessary for children under age 21. TennCare also covers generic buprenorphine, Subutex and Suboxone for opiate addiction. The applicant reports conducting a telephonic survey on March 25, 2013 of all 12 OTPs and finding that none accepted TennCare. The applicant indicated TennCare participants (ages 21 and under) may submit claims to TennCare for reimbursement for services received from out-of-network methadone maintenance providers.

Note to Agency Members: The Addiction Treatment Act of 2000 allows qualifying physicians to receive a waiver from the special registration requirements in the Controlled Substances Act for the provision of medication-assisted opioid therapy. This waiver allows qualifying physicians to practice medication-assisted opioid addiction therapy with Schedule III, IV, or V narcotic medications specifically approved by the Food and Drug Administration (FDA). On October 8, 2002 Subutex® (buprenorphine hydrochloride) and Suboxone® tablets (buprenorphine hydrochloride and naloxone hydrochloride) received FDA approval for the treatment of opioid addiction. The physician has the capacity to refer addiction therapy patients for appropriate counseling and other non-pharmacologic therapies, and that the physician will not have more than 30 patients on addiction therapy at any one time for the first year. (Note: the number of a physician's practice locations does not affect the 30-patient limit. One year after the date on which the physician submitted the initial notification, the physician will be able to submit a second notification stating the need and intent to treat up to 100 patients.)
 Source: http://buprenorphine.samhsa.gov/waiver_qualifications.html

The following chart reflects the TennCare top five (5) drugs by payment amount for the first quarters of 2011 and 2012. Buprenorphine/Naloxone was ranked number #4 in payment amount (\$3,668,218) in the 1st quarter of 2011 and #5 in

Tri-Cities Holdings, Inc.

CN1302-005

June 26, 2013

PAGE 12

2012 (\$2,211,589). There appears to be a 65.8% decrease in the dollar amount of Buprenorphine/Naloxone reimbursed by TennCare from the 1st quarter of 2011 to the 1st quarter of 2012. If the 2012 first quarter amount of \$2,211,589 were annualized, the amount for 2012 reimbursed by TennCare statewide for Buprenorphine/Naloxone would be \$8,846,356.

**TennCare
Top 5 Drugs by Payment Amount for Adults
First Qtr.2011 & 2012**

Rank	Drug 1 st Qtr. 2012	Payment 1 Qtr. 12	Rank 2011	Payment 1 Qtr. 2011
1	Aripiprazole	\$4,765,688	2	\$4,147,591
2	Dexlansoprazole	\$3,483,676	5	\$2,878,886
3	Olanzapine	\$2,877,449	3	\$3,973,118
4	Teleprevir	\$2,574,011	-	\$382,965
5	Buprenorphine/Naloxone	\$2,211,589	4	\$3,668,218

Source: TennCare Drug Utilization Review Advisory board, September 11, 2012
<https://tnm.providerportal.sxc.com/rxclaim/TNM/DUR%20Presentation%2009112012.pdf>

The SAMSHA (Substance Abuse and Mental Health Services Administration) physician and treatment locator for physicians certified for Buprenorphine Treatment indicates there are 77 certified physicians and one (1) facility (Indian Path Medical Center) in the proposed 9 county service area. According SAMSHA, there are 17 physician providers certified for Buprenorphine Treatment in Bristol, 2 in Blountville, 16 in Kingsport, 29 in Johnson City, 2 in Gray, 3 in Mountain Home, 4 in Morristown, 3 in Elizabethton and 1 in Unicoi.

HSDA staff analysis of the current SAMSHA buprenorphine certified providers practicing in the State of Tennessee revealed the following:

- There are 298 unduplicated SAMSHA buprenorphine certified providers statewide
- The proposed nine county service area has 77 unduplicated SAMSHA certified buprenorphine providers
- The proposed service area represents 600,895, or 9.4% of the State of Tennessee 2013 population of 6,414,297, but has 25.8% of the statewide buprenorphine certified providers

Source: http://buprenorphine.samhsa.gov/bwns_locator/

The applicant's proposed direct patient care staffing includes 1 contract Medical Director, 1 FTE Program Director, 1 FTE Charge Counselor, 1 FTE Charge Nurse,

Tri-Cities Holdings, Inc.

CN1302-005

June 26, 2013

PAGE 13

2 FTE LPN Dosing Nurse and 12 FTE Substance Abuse Counselors. The applicant notes the clinical staff will satisfy State Minimum Staffing Qualification Program Requirements for an OTP. The applicant states the industry guidelines are 50 patients per counselor. The applicant does not have current plans to hire a security guard but will do so if the need arises.

The applicant projects \$1,782,144 in total gross revenue on 530 clients during the first year of operation increasing to \$3,903,715 on 1,056 clients in Year 2 (approximately \$3,362 to \$3,697 per client, respectively). Net Operating Income less Capital Expenditures will equal \$7,638 in Year 1 increasing to \$565,578 in Year 2.

The applicant will provide charity care at the rate of approximately 2.0% of total gross revenue in Years 1 and 2 (\$35,643 or approximately 11 clients increasing to approximately \$78,074 or 21 clients). For comparative purposes, in June 2009 the Agency reviewed Upper Cumberland Private Clinic (CN0903-013D) which was proposed to be located in Spencer, Tennessee. Charity Care was proposed at the rate of approximately 10% of total gross revenue in Year 1 increasing to approximately \$393,357.00 or 13.3% of total gross revenue in Year 2 of operations.

The applicant states the facility will require no structural modifications and has sufficient parking. The interior structure will require renovation. The renovated cost is \$160,000 or \$20.00 per square foot. The renovation will include:

- Partitioning large rooms to create offices for counselors, doctors and the Executive director
- Partitioning large rooms and adding plumbing to build examination and lab rooms
- Constructing dosing rooms and associated dosing windows
- Constructing a room for the pharmacy and associated medicine vault
- Constructing a check-in booth
- The addition of electrical, cabling, video and communications.

After completion, the interior structure will include 1 large waiting area, 1 exam room, 1 pharmacy (dosing equipment and vault), 13 counseling rooms, 2 dosing rooms, 1 group room, American with Disabilities (ADA) compliant restrooms, an unfinished small storage area, and 1 employee break room. The applicant states the lobby area will accommodate 153 people at one time.

The total estimated project cost is \$670,000.00 which includes \$25,000.00 for Architectural and Engineering Fees, \$30,000.00 for Legal, Administrative, and Consultant Costs, \$160,000.00 for Site Preparation Costs, \$23,500 for Moveable

Tri-Cities Holdings, Inc.

CN1302-005

June 26, 2013

PAGE 14

Equipment, \$20,000 for Office Equipment, \$320,000 for Lease Expense, \$8,500 for Patient Software, \$80,000 for Operating Loss Costs, and \$3,000 for CON filing fees.

The project will be financed by cash reserves of Kester L.P. A March 27, 2013 letter from Mike Fenton, Senior Vice President of Maxim Group, which is investment banking, securities and investment management firm, attests to the availability of cash in the amount of \$762,888.60 to finance the proposed project.

The applicant indicates the Commission on Accreditation of Rehabilitation Facilities (CARF) will accredit the facility.

The applicant provided documentation of its required statutory notices to state, county and local area government officials, including State Senator Rusty Crowe, State Representative James (Micah) Van Huss, Washington County Mayor Dan Eldridge, and City of Johnson City Mayor Jeff Banyas.

Public Hearing

Tennessee Health Services and Planning Act, 68-11-1608 (b), states "upon request by interested parties or at the direction of the executive director, the staff of the agency shall conduct a fact-finding public hearing on the application in the area in which the project is to be located". A public hearing was requested for this application. The hearing was held on May 28, 2013 in the Jones Meeting Center, Johnson City Public Library, 100 W. Millard Street, Johnson City (Washington County), Tennessee. A copy of the minutes and transcript are attached behind the application.

The applicant has submitted the required corporate and real estate lease documentation. HSDA staff reviewed these documents. A copy will be available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency office.

Should the Agency vote to approve this project, the CON would expire in two years.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:

There are no other Letters of Intent, pending applications, denied applications, or outstanding Certificates of Need for this applicant.

CERTIFICATE OF NEED INFORMATION FOR OTHER PROVIDERS IN THE SERVICE AREA:

Tri-Cities Holdings, Inc.

CN1302-005

June 26, 2013

PAGE 15

There are no letters of intent, denied or pending applications, or outstanding Certificates of Need for other health care organizations in the service area proposing this type of service.

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCES ABUSE SERVICES FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

PME

06/19/2013

LETTER OF INTENT



2013 MAR 4 am 10:33
LETTER OF INTENT

TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Johnson City Press which is a newspaper of general circulation in Washington, Tennessee, on or before March 7, 2013 for one day.
(County) (Month / day) (Year)

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency,

Tri-Cities Holdings LLC d/b/a Trex Treatment Center

NA

(Name of Applicant)

(Facility Type-Existing)

owned by: Tri-Cities Holdings LLC with an ownership type of Limited Liability Company

and to be managed by: Manager Steve Kester intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]:

Establishment of a nonresidential substitution-based treatment center for opiate addiction offering methadone and buprenorphine which is designed to treat opiate addiction by preventing symptoms of withdrawal. In addition, we will offer individual counseling services and group therapy to help break the cycle of addiction and provide patients the life skills and resources to serve as productive members of their communities, families and employers.. The location of the proposed project is 5 Wesley Court, Johnson City, Tennessee 37601. The project cost is estimated to be \$670,000.

The anticipated date of filing the application is: March 7, 2013

The contact person for this project is Steve Kester Manager

(Contact Name)

(Title)

who may be reached at: Tri-Cities Holdings LLC 6555 Sugarloaf Parkway Suite 307-137

(Company Name)

(Address)

Duluth

(City)

Georgia

(State)

30097

(Zip Code)

404-664-2616

(Area Code / Phone Number)

St W. Kester

(Signature)

March 1, 2013

(Date)

swkester@gmail.com

(E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
The Frost Building, Third Floor
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Copy

Supplemental #1

Tri-Cities Holdings, LLC

CN1302-005

2013 MAR 25 PM 12 05

COPY

**Application for
CERTIFICATE OF NEED**

Filed with the

**Tennessee Health Services and
Development Agency**

CN1303-005

Filed by:

Tri-Cities Holdings LLC

d/b/a Trex Treatment Center

6555 Sugarloaf Parkway Suite 307-137

Duluth, GA 30097

March 22, 2013

Table of Contents

SECTION A. APPLICANT PROFILE	1
SECTION B: PROJECT DESCRIPTION	
I. Executive Summary	4
II. Project Narrative	6
III. A. Plot Plan	10
III. B. Transportation	14
IV. Floor Plan	15
SECTION C. GENERAL CRITERIA FOR CERTIFICATE OF NEED	
Need	17
Economic Feasibility	29
Orderly Development	42
Proof of Publication	46
Development Schedule	49

March 25, 2013

12:15pm

1. **Name of Facility, Agency, or Institution**

Tri-Cities Holdings LLC dba Trex Treatment Center

Name

4 Wesley Court

Street or Route

Johnson City

City

TN

State

Washington

County

37601

Zip Code

2. **Contact Person Available for Responses to Questions**

Steven W. Kester

Name

Tri Cities Holdings LLC

Company Name

6555 Sugarloaf Parkway, Suite 307-137

Street or Route

Same

Association with Owner

Duluth

City

404-664-2616

Phone Number

Managing Member

Title

swkester@gmail.com

Email address

GA

State

30097

Zip Code

404-537-3780

Fax Number

3. **Owner of the Facility, Agency or Institution**

Tri-Cities Holdings LLC

Name

6555 Sugarloaf Parkway, Suite 307-137

Street or Route

Duluth

City

GA

State

404-664-2616

Phone Number

Gwinnett

County

30097

Zip Code

4. **Type of Ownership of Control (Check One)**

A. Sole Proprietorship

B. Partnership

C. Limited Partnership

D. Corporation (For Profit)

E. Corporation (Not-for-Profit)

F. Government (State of TN or
Political Subdivision)

G. Joint Venture

H. Limited Liability Company

I. Other (Specify)

✓

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND
REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

5. Name of Management/Operating Entity (If Applicable)

N/A (see added Attachment A-5 for bios and affiliations)

Name _____

Street or Route _____

County _____

City _____

State _____

Zip Code _____

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND
REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. Legal Interest in the Site of the Institution (Check One)A. Ownership ☐D. Option to Lease ☒B. Option to Purchase ☐E. Other (Specify) _____ ☐C. Lease of _____ Years ☐

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND
REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. Type of Institution (Check as appropriate--more than one response may apply)A. Hospital (Specify) _____ ☐I. Nursing Home ☐B. Ambulatory Surgical Treatment
Center (ASTC), Multi-Specialty ☐J. Outpatient Diagnostic Center ☐C. ASTC, Single Specialty ☐K. Recuperation Center ☐D. Home Health Agency ☐L. Rehabilitation Facility ☐E. Hospice ☐M. Residential Hospice ☐F. Mental Health Hospital ☐

N. Non-Residential Methadone

G. Mental Health Residential

Facility ☒Treatment Facility ☐O. Birthing Center ☐

H. Mental Retardation Institutional

P. Other Outpatient Facility

Habilitation Facility (ICF/MR) ☐(Specify) _____ ☐Q. Other (Specify) _____ ☐8. Purpose of Review (Check) as appropriate--more than one response may apply)A. New Institution ☒

G. Change in Bed Complement

B. Replacement/Existing Facility ☐

[Please note the type of change

C. Modification/Existing Facility ☐

by underlining the appropriate

D. Initiation of Health Care

response: Increase, Decrease,

Service as defined in TCA §

Designation, Distribution,

68-11-1607(4)

Conversion, Relocation] ☐(Specify) _____ ☐H. Change of Location ☐E. Discontinuance of OB Services ☐I. Other (Specify) _____ ☐F. Acquisition of Equipment ☐

March 25, 2013

12:15pm

9. **Bed Complement Data***Please indicate current and proposed distribution and certification of facility beds.*

	<u>Current Beds Licensed</u>	<u>*CON</u>	<u>Staffed Beds</u>	<u>Beds Proposed</u>	<u>TOTAL Beds at Completion</u>
A. Medical					
B. Surgical					
C. Long-Term Care Hospital					
D. Obstetrical					
E. ICU/CCU					
F. Neonatal					
G. Pediatric					
H. Adult Psychiatric					
I. Geriatric Psychiatric					
J. Child/Adolescent Psychiatric					
K. Rehabilitation					
L. Nursing Facility (non-Medicaid Certified)					
M. Nursing Facility Level 1 (Medicaid only)					
N. Nursing Facility Level 2 (Medicare only)					
O. Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P. ICF/MR					
Q. Adult Chemical Dependency					
R. Child and Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>

*CON-Beds approved but not yet in service

10. Medicare Provider Number N/ACertification Type -11. Medicaid Provider Number N/ACertification Type -

12. If this is a new facility, will certification be sought for Medicare and/or Medicaid? No

13. Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area. Will this project involve the treatment of TennCare participants? No If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted or plans to contract.

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

March 25, 2013

- I. **Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.**

Proposed Services -- We seek to establish an outpatient opiate treatment program ("OTP") in Johnson City, Tennessee. We anticipate using buprenorphine, methadone and abstinence-based treatment for those suffering from opiate addiction. We will offer individual counseling services and group therapy to help break the cycle of addiction and provide patients the life skills and resources to serve as productive members of their communities, families and employers. We understand the concern of trading one addiction for another in perpetuity. Our commitment will be to give patients their independence back as soon as medically, morally and ethically possible.

Equipment--The only equipment used in treatment are the dispensing devices used to correctly administer medication doses.

Ownership Structure--The ownership of the facilities management and administration will be Tri-Cities Holdings LLC, a Duluth, Georgia-based company.

Service Area--The proposed service area will be the nine most northeastern counties of Tennessee that have convenient access from and to Interstate 81: Sullivan, Washington, Greene, Hamblen, Carter, Hawkins, Cocke, Unicoi and Johnson. This covers 100% of the population of Tennessee's Methadone Service Area #1, 97% of #2, and 70% of #3.

Need and Existing Resources -- The applicant can demonstrate the need for a non-residential treatment program for the Northeast Tennessee area. First and foremost, the abuse of prescription pain medication is an epidemic in the United States.¹ The rate of abuse is higher in the region we intend to serve.² Methadone maintenance treatment is the most effective treatment for opiate addiction according to the Center for Disease Control,³ the U.S. National Institute on Drug Abuse,⁴ the Center for Substance Abuse Treatment, the Institute of Medicine,⁵ the National Institute of Health,⁶ and the World Health Organization. There are no existing SAMHSA-designated methadone maintenance treatment programs in our proposed service area.

1. The nearest clinics are far away yet still get numerous patients from the proposed service area. No local option exists for the comprehensive medication management and counseling services that we will offer. A SAMHSA list of buprenorphine providers and in-patient treatment program in the proposed service area and it is included as Attachment B1.
 - a. The applicant's manager is the co-founder and part owner of nine treatment programs, including two in the Asheville area, 49 and 70 miles from the proposed location respectively (Crossroads Treatment Centers of Weaverville, NC and Asheville). Approximately 600 patients make the commute from Northeast Tennessee areas to the applicant's Asheville facilities.
 - b. There are three other OTPs in Asheville and two other OTP's in Boone, NC that report between 20-40% of patients being from northeast Tennessee (Western Carolina, CRC and Mountain Area Recovery Center in Asheville and Stepping Stone and McLeod in Boone).
 - c. Nearest Tennessee OTPs are in Knoxville, 104 miles away, owned by Behavioral Health Group ("BHG"). An admissions counselor on 2/25/2013 indicated BHG had nearly 400 patients from Northeast Tennessee area in their

¹<http://www.cdc.gov/homeandrecreationalsafety/rxbrief/>.

² An Analysis of Mental Health and Substance Abuse Disparities & Access to Treatment Services in the Appalachian Region, 2008, ARC.

³ <http://www.cdc.gov/idu/facts/methadonefin.pdf>.

⁴ <http://international.drugabuse.gov>.

⁵ Institute of Medicine, 1995. "Development of Medications for the Treatment of Opiate and Cocaine Addictions."

⁶ NIH Consensus Conference. Effective Medical Treatment of Opiate Addiction. JAMA 1998; 280:1936-1943.

programs.

2. Several other providers have tried to site clinics in the Northeast Tennessee area in 2012, 2010 and twice in 2003. The only company to go through the CON process had their application approved, only to be overturned on a technicality. The other companies stopped the application process because of zoning issues, for which our company has a plan to address. Since opiate addiction is significantly higher in 2013 than it was in 2003⁷, when a Johnson City CON was approved, the need is greater now.
3. The patients from Northeast Tennessee who travel many miles to the nearest OTP will also highlight the need in other ways. If a Johnson City patient travels 200 miles round trip to Knoxville, he or she will also consume approximately \$30 in gas and over three hours of drive time. That is a real hardship for patients, especially new patients who must come seven days per week. Under current rules, new patients from the Northeast Tennessee area driving to Knoxville (the closest clinic in TN) must drive up to 9,000 extra miles in the first 45 days of treatment. Of the barriers to access to healthcare, geographic distance is the top of the list, even higher than access to healthcare insurance⁸. For every patient that makes the commute, several are most likely foregoing treatment because they can't afford the time, money or energy.
4. In 2003, a CON was granted for a OTP in Johnson City, but was overturned on a technicality.⁹ Since this time, the CDC has declared prescription medication abuse an epidemic, and SAMHSA has noted a 300% increase in emergency room visits for opiate-related cases.¹⁰
5. The Tennessee Depart of Health clearly recognizes this problem. The Safety Subcabinet Working Group issued a report in 2012 titled "Prescription Drug Abuse in Tennessee"¹¹ that has significant data to highlight the problem (drug overdoses going up by 250% over 10 years overtaking motor vehicle deaths, suicides and homicides, a quarter million Tennesseans abusing opiates, the high cost associated with those who abuse to the State, etc.). The Report listed 3 recommendations, one of which was more treatment options. The last CON approved for a treatment center was in 2009.

Financial Feasibility--Tri-Cities Holdings (TCH) has all of the necessary resources to execute this project. Steve Kester is the leader of TCH and has successfully opened 9 OTPs in four states in five years. Each facility has received full accreditation and the facilities' need have been well-justified and financially feasible. In addition to leadership and experience, the company has the financial resources to see this project through fruition. We are planning to be supported through self-payment from patients and not seek revenue through programs such as TennCare or Medicare.

This center is projected to have more than 500 patients when fully operational. Mr. Kester is co-founder and part owner of 9 OTP clinics, which serve approximately 4,000 patients and knows first-hand that clinics of this size are financially healthy. The financial pro forma and various scenarios show a financially healthy firm.

Project Cost--The project's costs are expected to be approximately \$670,000 including lease costs, construction build-out/renovation, operating carry loss and other project-related costs.

Funding--This project will be funded personally by Steve Kester, Managing Member of TCH. Mr. Kester has the monies in reserve and committed to more than cover the project costs and start-up operating loss.

Staffing--Staffing of the center would include: Center Executive Director, Medical Director, Nurses, Counselors, Intake Specialist, Administrator/Receptionist, Accounting, Human Resources, and Legal Support Staff.

[Note: responses to supplemental questions related to this section are included in Attachment B1 -- Supplemental Questions in order to keep the length in compliance.]

⁷ SAMHSA (2009), see Office of National Drug Control Policy, <http://www.whitehouse.gov/ondcp/prescription-drug-abuse>.

⁸ Veterans Affairs on Rural Health, (2011).

⁹ <http://www.mapinc.org/drugnews/v03/n702/a01.html>

¹⁰ <http://www.samhsa.gov/data/DAWN.aspx>

¹¹ http://tn.gov/mental/policy/presc_drug_abuse.shtml

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

- A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of \$5 million) and other facility projects (construction cost in excess of \$2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project. If the project involves none of the above, describe the development of the proposal.

We have chosen a facility that will require no structural modifications and has ample parking. The current structure includes a large lobby (which will be re-purposed as a waiting area), several large conference rooms, ample ADA bathrooms for men and women, and an unfinished storage area.

The renovation construction involved will include:

- Partitioning large rooms to create offices for counselors, doctors and the Executive Director
- Partitioning large rooms and adding plumbing to build examination and lab rooms
- Constructing dosing rooms and associated dosing windows
- Constructing a room for the pharmacy and associated medicine vault
- Constructing a check-in booth
- Adding the electrical, cabling, video and telephony for the above rooms

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
Lobby					1,230		1,230	\$10		
Counselors offices					3,200		3,200	\$24.30		
Medical/Lab					300		300	\$24.30		
Dosing					400		400	\$24.30		
Administration					250		250	\$24.30		
Meeting					420		420	\$10		
Common					1,408		1,408	\$10		
Pharmacy					300		300	\$30		
Maint./storage					150		150	\$10		
Bathrooms					300		300	\$40		
Breakroom					250		250	\$24.30		
B. Unit/Dept. GSF Sub-Total					8,208		8,208	\$20		
C. Mechanical/ Electrical GSF										
D. Circulation /Structure GSF										
E. Total GSF					8,208		8,208	\$20		

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

This is strictly an outpatient facility and will require no beds.

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. Adult Psychiatric Services
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing Beds.

This is a proposed non-residential methadone treatment facility and intends to serve the Northeast Tennessee area, which includes Johnson City, Kingsport, Bristol and the surrounding communities. According to the 2011 US Census, the 9 most northeastern counties of Tennessee had a population of 600,084, a growth of over 2,431 from 2010.

The Tennessee Health Services and Development Agency has recognized the need for a NRMTC 10 years ago when it granted a CON for a Johnson-City based program. Since that time, the population has grown and, according to the CDC, the prescription-pain medication abuse has

March 25, 2013
12:15pm

reached "epidemic levels" in the country. Further, in 2008 the Appalachian Regional Commission, a Federal-State partnership, concluded that the prescription medication abuse was higher in the southern Appalachian region, which includes northeastern Tennessee, than the rest of the U.S. and part of the problem is lack of available treatment programs¹². In fact, this 228-page report's academic partner was East Tennessee State University, located in Johnson City, Tennessee.

In summary, the abuse of prescription pain medication is an epidemic in the U.S.; it's higher in the region we intend to site; there are no NRMFTF treatment programs; and lack of treatment programs is part of the problem. We have much work to do.

We are not the first provider to recognize this need. At least four others have formally tried through the CON or local permitting process, and TCH believe nearly every major provider has informally researched the idea.

D. Describe the need to change location or replace an existing facility.

Not Applicable (NA). This will be a new facility.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of \$1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment (not replacing existing equipment):

a. Describe the new equipment, including:

- 1. Total cost ;(As defined by Agency Rule).**
- 2. Expected useful life;**
- 3. List of clinical applications to be provided; and**
- 4. Documentation of FDA approval.**

b. Provide current and proposed schedules of operations.

2. For mobile major medical equipment:

- a. List all sites that will be served;**
- b. Provide current and/or proposed schedule of operations;**
- c. Provide the lease or contract cost.**
- d. Provide the fair market value of the equipment; and**
- e. List the owner for the equipment.**

3. Indicate applicant's legal interest in equipment (i.e., purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of

¹² An Analysis of Mental Health and Substance Abuse Disparities & Access to Treatment Services in the Appalachian Region, 2008, ARC

the lease and the anticipated lease payments.

Not Applicable (NA). The most expensive equipment in the facility will be a methadone dispensing system and a vault for safe storage of medicine. Both items cost less than \$10,000.

III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which must include:

1. Size of site (in acres);
2. Location of structure on the site; and
3. Location of the proposed construction.
4. Names of streets, roads or highway that cross or border the site.

Our proposed location is at 4 Wesley Court, in Johnson City, Tennessee. This location is a freestanding building in an industrial area, and is zoned for medical services by Johnson City. The location is 0.2 mile from Quillen Rehabilitation Hospital.

The location is situated on 1.66 acres, and the square footage of the facility is 8,260 square feet. The facility has parking on all four sides plus an adjacent side lot. Street parking is permitted. The capacity of the facility and street parking is 1,000 spaces. This size of a facility and accompanying parking can accommodate 1,000 patients with a one-shift operation and more if afternoon and evening programs are offered. 2,000 patients in treatment requires approximately 100 parking spaces because of take-home policies (where patients do not have to come every day), carpooling, public transportation, multiple shifts, and staggering of arrival times.

The facility is on a cul-de-sac with industrial and commercial customers as neighbors: a construction supply company, a construction company, and an empty lot. Most of the traffic at our facility is expected between 5AM and 7 AM so patients can get to work or school. This traffic will occur before the neighboring businesses are open. The traffic on the street is very light given the limited number, hours of operation and nature of the businesses.

Johnson City has strict zoning regulations regarding locations of NRMTEs. The applicant has spent significant time finding a location that best meets the City's zoning requirements. The site is well outside all limits that the city has schools, daycare, parks or locations that sell alcoholic beverages:

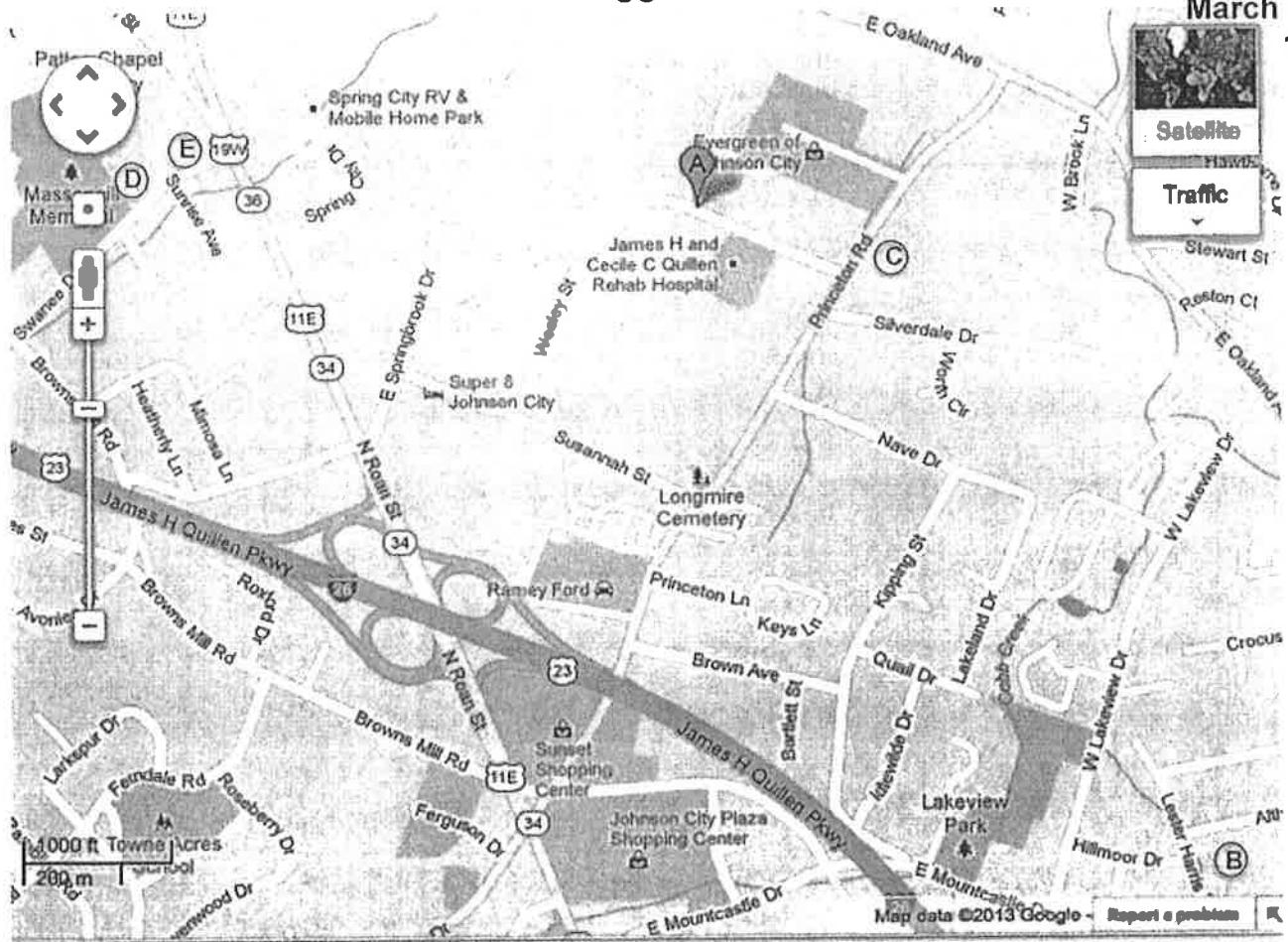
Place	Minimum Requirements	Closest Location	Actual distance ¹³	Site Reference on map below
Our proposed site				A
School	200 feet	Fairmont Elementary School 1405 Lester Harris Rd Johnson City, TN	6,135 feet	B
Day care	200 feet	Princeton Prep, 504 Princeton Rd, Johnson City, TN 37601	1,336 feet	C
Park	200 feet	Massengill Memorial. 2801 State Highway 36. Johnson City, TN	3,199 feet	D
Alcohol	200 feet	Cootie Brown's 2715 N Roan St, Johnson City, TN	3,183 feet	E

Map of Above Locations

¹³ Shortest distance between property lines, "as the crow flies", using Google maps and freemapttools.com.

March 25, 2013

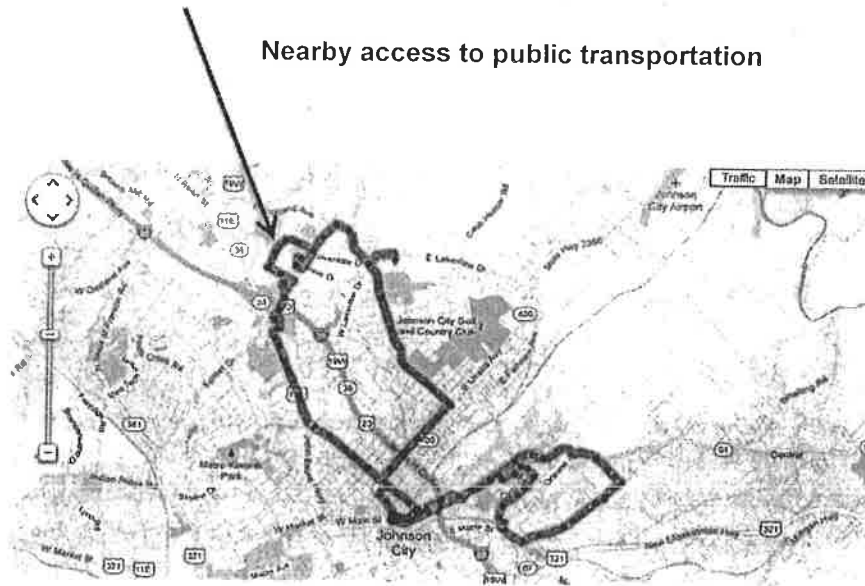
12:15pm



(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

March 25, 2013
12:15pm

Our proposed site is less than a quarter mile to transit stops on Johnson City's Transit System Blue Route. Drop offs and pickups are on the hour, starting at 6:26 in the morning.



The proposed location is less than one mile to I26, a major interstate and a 20-minute drive from Kingsport. The other major city is Bristol, which is 22 miles away. Both of these distances represent a major improvement of the driving distances patients currently go for treatment, as shown below:

Patient's Domiciled City	Closest treatment center: Weaverville, NC (miles)	Closest treatment center in Knoxville, Tennessee (miles)	Distance to our proposed center (miles)	Round-trip savings (miles)
Johnson City	45	104	0	90 - 208
Kingsport	67	99	22	90 - 154
Bristol	70	113	22	96 - 182

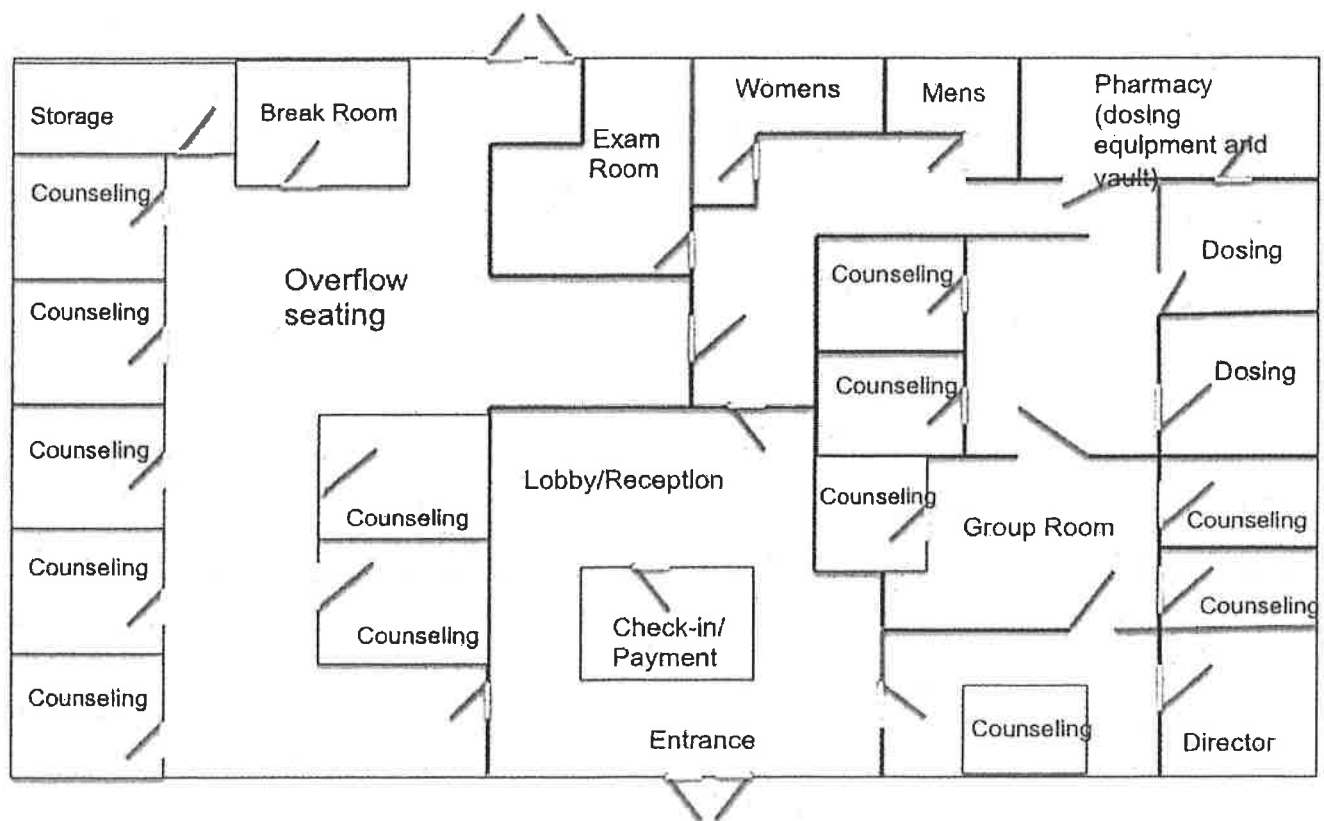
Since close to 1,000 patients from the Northeast Tennessee area make this commute to clinics in Knoxville and North Carolina¹⁴--often in dangerous winter conditions--the accessibilities of the proposed facility is a major improvement over the nearest alternatives.

¹⁴ TCH estimate based on clinics owned by TCH principal in North Carolina and discussion with Knoxville clinics.

- IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.

NOTE: DO NOT SUBMIT BLUEPRINTS. Simple line drawings should be submitted and need not be drawn to scale.

The lobby area could accommodate 153 seats, more than enough for the maximum number of patients at one time plus guests they may bring. Overflow seating, should we need it, would be in the common area on the left side of the building, shown on the diagram. The inside of the facility will be non-smoking. Smoking for patients will be accommodated in the grassy area in front of the building; there is an awning during inclement weather. Smoking for staff will be accommodated outside the rear exit of the building.



All counseling and exam rooms are private.

Our proposed services will also include comprehensive referral services to patients in order to equip them with the resources for independence outside of our treatment. A list of these services and referrals is provided in Attachment B4 – Referral Sources.

V. For a Home Health Agency or Hospice, identify:

- 1. Existing service area by County;**
- 2. Proposed service area by County;**
- 3. A parent or primary service provider;**
- 4. Existing branches; and**
- 5. Proposed branches.**

Not Applicable (NA).

NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.

a. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

[Note: The criterion wording from Tennessee's Health: Guidelines for Growth for NON-RESIDENTIAL METHADONE TREATMENT FACILITIES (NRMTF) are stated below in **bold italics**. Our response follows in normal font.]

NEED

A non-residential narcotic treatment facility should provide adequate medical, counseling, vocational, educational, mental health assessment, and social services to patients enrolled in the opioid treatment program with the goal of the individual becoming free of opioid dependency.

Applicant will comply with TDMHDD rules for qualifications and training of all staff. As required by State rules, Applicant will be medically supervised by a Board-certified physician who has expertise in opioid dependency. Applicant will provide continuous and intensive counseling, services, and mental health assessments aimed at helping the patient become free of opioid dependency as soon as possible, and to manage life successfully on methadone maintenance, until that time. This will include educational services delivered through the counseling staff and referral to vocational services.

The need for non-residential narcotic treatment facilities should be based on information prepared by the applicant for a certificate of need which acknowledges the importance of considering the demand for services along with need and addressing and analyzing service problems as well.

The assessment should cover the proposed service area and include the utilization of existing service providers, scope of services provided, patient origin, and patient mix.

The assessment should consider that the users of opiate drugs are the clients at non-residential narcotic treatment facilities, and because of the illegal nature of opiate drug use, data will be based on estimates, actual counts, arrests for drug use, and hospital admittance for drug abuse.

The Applicant acknowledges this and is in compliance. The need is summarized below:

Area	Prescription Drug Addiction Problem	Source And Statistics/Quote	Opiate Treatment Programs (Otps)	OTP's Per 1,000,000 Residents
United States	"Epidemic"	<p>Centers For Disease Control¹⁵</p> <ul style="list-style-type: none"> Just under 10 percent of the US population abuses opiates at some point in their lifetime Drug overdose death rates in the United States have more than tripled since 1990 and have never been higher. 	1,077	3.42
Tennessee	Worst than above	<p>Tennessee Safety Subcabinet Working Group¹⁶</p> <ul style="list-style-type: none"> In 2008, Tennessee's drug overdose rate was 25% high than the overall U.S. Tennessee's rate climbed 11% two years later; 242% from 2000 – 2010 Drug overdose has become the leading cause of accidental death in Tennessee 	12	1.86
Proposed Service Area	Worse than above	<p>Appalachian Regional Commission¹⁷</p> <ul style="list-style-type: none"> The opiate addiction rate of the southern Appalachian Region (included proposed service area) is 8% higher than non-Appalachian areas A Johnson City Professor wrote a 2010 report titled "<i>Prescription Drug Abuse and the Pill Pipeline in Appalachia</i>"¹⁸ 	0	0

[The assessment should also include:] A description of the geographic area to be served by the program;

¹⁵ "Policy Impact: Prescription Painkiller Overdoses",
<http://www.cdc.gov/homeandrecreationalsafety/rxbrief/>

¹⁶ "Prescription Drug Abuse in Tennessee",
http://tn.gov/mental/policy/persc_drug_docs/Prescription%20Drug%20Use%20in%20TN%202012%20R2.pdf

¹⁷ "Disproportionately High Rates of Substance Abuse in Appalachia",
http://www.arc.gov/news/article.asp?ARTICLE_ID=113

¹⁸ http://www.etsu.edu/cph/NewsEventsDocuments/Alarmingly_High_by_Robert_P._Pack.pdf

Complies. The proposed service area for this facility would be the nine most northeastern counties of Tennessee. These counties include (in order of size): Sullivan, Washington, Greene, Hamblen, Carter, Hawkins, Cocke, Unicoi and Johnson.

[The assessment should also include:] Population of area to be served;

Complies. Based on the 2011 US Census, the population of the proposed serve area was 600,084, or just under 10% of Tennessee's population. The largest city in this service area is also the proposed site of our project: Johnson City, population 63,800.

[The assessment should also include:] The estimated number of persons, in the described area, addicted to heroin or other opioid drugs and an explanation of the basis of the estimate;

Complies. We estimate that there are approximately between 12,000 and 24,000 adults who are addicted to opiates (heroin and prescription pain pills) in the proposed service area. This range is derived using the following methods:

- SAMHSA (Substance Abuse and Mental Health Services Administration - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES) reports that heroin use was 0.3% in 2011 and prescription pain medication abuse was 1.7%¹⁹. Combined, this would yield 12,000 opiate abusers or opiate dependents from the proposed service area.

- In Tennessee's Department of Mental Health and Substance Abuse Services report, "Prescription Drug Abuse In Tennessee" by the Safety Subcabinet Working Group, reported that almost 250,000 Tennesseans older than 12 reported abusing prescription opioids in 2009. Tennessee's population was approximately 6.3 million in 2009, yielding an incidence rate of 3.9%. This alone would yield approximately 23,800 opiate abusers or opiate dependents from the proposed service area.

[The assessment should also include:] The estimated number of persons, in the described area, addicted to heroin or other opioid drugs presently under treatment in methadone and other treatment programs;

Complies. We estimate that the number of individuals in methadone treatment from the proposed service area is between 950 and 1,500.

- Applicant attempted to get Registry Data of NRMFTF enrollment by county from the Tennessee Department of Mental Health and Substance Abuse Services, but the Department does not release this data publically. This is a policy change from prior NRMFTF CONs where the data was provided. However, the most recent release of Registry Data was for CY2008 (Attachment C, Need, 1a.), which showed that 8,889 Tennessee-domiciled patients were enrolled in Tennessee opiate treatment programs (not including Tennessee residents in out-of-state programs) and the State's population was 6,156,719, or a rate of 144.4 patients per 100,000 residents. Applying this rate to Applicant's proposed service area, would yield 866 patients, which is low because of a) the epidemic growth of opiate abuse since 2008, and b) the number of residents going to out-of-state programs, such as in Applicant's proposed service area.

- We instead relied on data from the closest NRMFTFs in the Asheville area, Knoxville, and Boone, NC. The applicant's manager is a co-founder and partial owner of two Asheville-area

¹⁹ <http://www.samhsa.gov/data/nsduh/2k11results/nsduhresults2011.htm#Ch2>

clinics and was able to get actual data of patients attending treatment at these clinics who also live in the proposed service area. Some other clinics participated in a telephone survey about patients attending those clinics who lived in the proposed service area. Finally, for non-participating clinics, extrapolations were done, based on the other clinics' responses. Based on the methodology described above, we estimate that the number of patients from the proposed service area attend clinics in the following locations:

- o Knoxville: 300 – 400, based on telephone interviews
- o Asheville: 600 – 900, based on Applicant's owned data and extrapolation
- o Boone: 50 – 100, based on telephone interviews
- o Total: 950 – 1,500

Also important is the consideration of the number of addicts that forego treatment because of distance. The U.S. Department of Veteran affairs did a study of this, and their findings were sobering. Substance abuse patients who traveled 10 miles or less were 2.6 times more likely to obtain aftercare than those who traveled more than 50 miles²⁰. This says that there may be 2,470 – 3,900 opiate addicts in the area that would seek treatment if it were closer.

The economic and social costs of untreated patients who would seek treatment if it were closer are significant. Medicaid-paid medical, mental health, and long-term care costs are significantly lower for persons addicted to opiates who participate in methadone treatment, compared to opiate addicts who remain untreated²¹. The study, based out of the Washington state, concurs with what Tennessee has found. In the 2010 report "Prescription Drug Abuse In Tennessee" the State found that, "Abuse of prescription opioids is the number one drug problem for Tennesseans receiving state-funded treatment services."

The Applicant estimates the economic savings to the State to be \$765 per patient per month based on the Washington and Tennessee studies. When applied to the estimated untreated population that would seek treatment in the proposed service area equates to \$22.7 - \$35.8 million State-funded savings per year. Further, the study found that patients that stay in methadone treatment for more than a year are 61% less likely to be re-arrested and 83% less likely to commit a felony than those left untreated.

[The assessment should also include:] Projected rate of intake and factors controlling intake;

Complies. Applicant projects that the rate of intake will be 50 patients per week or less. The factors controlling intake will include the mix of transfers patients versus new patients (new patients

²⁰ Center for Health Care Evaluation and Health Economics Resource Center, Veterans Affairs, Palo Alto Health Care System, Palo Alto, CA, USA. "The influence of distance on utilization of outpatient mental health aftercare following inpatient substance abuse treatment."

²¹ Washington State Department of Social & Health Services, "Methadone Treatment For Opiate Addiction Lowers Health Care Costs And Reduces Arrests And Convictions"

require more time to admit), the number of staffing hours we can secure from our medical doctor(s), and the rate at which new patients will learn of our clinic.

[The assessment should also include:] Compare estimated need to existing capacity.

Also, consideration should be given to the reality that existing facilities can expand or reduce their capacity to maintain or treat patients without large changes in overhead

Complies. Currently there are no NRMFTs in this service area. We expect that the overwhelming percentage of patients who will use our proposed location would live in the proposed service area. According to phone screens and Applicant's knowledge of data at owned clinics, patient census has grown significantly in recent years with the growing problem of opiate addiction in the U.S., Tennessee, and surrounding areas.

Applicant contacted the Tennessee Department of Mental Health and Substance Abuse Services to obtain central registry data to accurately quantify the number of patients enrolled in Tennessee NRMFTs from the proposed service area. This data has been supplied by the Department of Mental Health for prior CONs. However, Applicant was informed that the Department changed its policy regarding releasing the data for such requests, and Applicants request was denied.

To estimate the number of patients from the proposed service area enrolled in opiate treatment programs, the Applicant relied on data from the clinics he has a partial ownership interest in (Asheville and Weaverville, NC), and telephone surveyed clinics in non-owned clinics in Knoxville, Asheville, and Boone, NC.

[Note: The Applicant also reviewed the Five Principles for Achieving Better Health that are contained in Tennessee's full State Health Plan. The Five Principles are listed below in ***bold italics***, followed immediately by Applicant response in normal font.]

1. The purpose of the State Health Plan is to improve the health of Tennesseans;

Complies. The Centers For Disease controls describes methadone treatment as "*needed, life-saving services*". The benefits cited include reduced or stopped use of injection drugs; reduce risk of acquiring or transmitting HIV, hepatitis B or C or bacterial infections; reduce mortality; reduced criminal activity; improved family stability; and improved pregnancy outcomes²².

2. Every citizen should have reasonable access to health care;

Complies. This proposed facility provides needed access where a demonstrated need exists. The proposed service area is consistent with the State's Methadone Service Areas that balance population and access.

3. The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the state's health care system;

Complies. This project seeks no public funding, would compete in an open market, and provides treatment consistent with the State's Methadone Service Areas.

²² <http://www.cdc.gov/idu/facts/methadonefin.pdf>

March 28, 2013

9:00 am

4. ***Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers; and***

Complies. The Applicant recognizes and accepts the critical role that State and Federal regulating and licensing agencies play to ensure quality care.

5. ***The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.***

Complies. The Applicant looks forward to working with State and local officials to create, recruit and retain 20-40 highly-paid and trained healthcare jobs.

Service Area

The geographic service area should be reasonable and based on an optimal balance between population density and service proximity.

Complies. The Applicant's proposed service area is comprised of 100% of the "Methadone Service Area #1" defined by the State in 2002; 97% of "Methadone Service Area #2" and 70% of "Methadone Service Area #3". These Methadone Service Areas, or MSA were specifically addressed to balance population with proximity to care. Attachment C 3, "Tennessee Methadone Service Areas", details the areas. Basically, where the State said there should be three facilities in 2002, there are none today, and the need has become materially more pronounced since that time.

The relationship of the socio-demographics of the service area and the projected population to receive services should be considered. The proposal's sensitivity to and the responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, and low-income groups.

Complies. Opioid dependency is prevalent in every adult age group and race in the United States. The CDC notes that opioid overdoses have increased over 400% in the decade from 1999 - 2009²³. This report also clearly shows that opioid abuse and overdose cuts across genders, age groups, race, metropolitan status and economics. Further, the report shows that Tennessee is among the 12 states with the highest per-capita overdose rates in the nation.

b. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c).

Not applicable

²³ <http://www.fda.gov/downloads/Drugs/NewsEvents/UCM300859.pdf>

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

We estimate that the facility would eventually serve approximately 1,100 – 1,200 patients at a given time. The biggest demands on a NRMFTF are parking spaces and counselors' offices. 1,200 patients would require 24 counselors (50 patients per counselor per industry guidelines) and approximately 120 peak parking spaces in a one-shift operation. After the facility treated 800 patients, we would anticipate running a morning and an afternoon program, where the morning would take approximately 60% of the demand and the afternoon would take approximately 40% of the demand. In this scenario, we would need 15 counselor offices for the morning program and 72 parking spaces. The proposed facility can meet the peak needs of the anticipated patient population.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).

Our proposed service area is shown in the darkened areas of the map below and also more clearly in Attachment C-3 Proposed Service Area. The nine counties comprising our proposed serve area are: Sullivan, Washington, Greene, Hamblen, Carter, Hawkins, Cocke, Unicoi, and Johnson. The map below and in Attachment C-3 shows the nine most northeastern counties of Tennessee. Currently, there are no NRMFTFs in this service area.

Proposed Service Area



Proposed Service Area includes the counties that are those boxed above, including Sullivan, Washington, Greene, Hamblen, Carter, Hawkins, Cocke, Unicoi and Johnson. Washington, Carter, Johnson and Unicoi counties form Methadone Service Area #1, Sullivan and Hawkins county are in MSA #2, and Green, Cocke and Hamblen counties are in MSA #3.

Distance is a long-recognized barrier to treatment.²⁴ Studies show that treatments rates fall

²⁴ K. Beardsley, E. D. Wish, D. B. Fitzelle, K. O'Grady, and A. M. Arria, "Distance traveled to outpatient drug treatment and client retention," *Journal of Substance Abuse Treatment*, vol. 25, no. 4, pp. 279–285, 2003, cited in "Distance Traveled and Cross-State Commuting to Opioid Treatment Programs in the United States," *Journal of Environmental and Public Health*, Volume 2011, Article ID 948789 (additional citations therein).

substantially as commute distances increase beyond 25 miles.²⁵ The U.S. Department of Veterans affairs did a study of this, and their findings were sobering. Substance abuse patients who traveled 10 miles or less were 2.6 times more likely to obtain aftercare than those who traveled more than 50 miles²⁶. Tennessee Department of Health produced similar results in 2001 a report concluded "[t]he closer one lives to a treatment program, the greater likelihood of participation. The current rate of participation is nearly twice as high for persons living in or close to one of the five counties (Shelby, Davidson, Knox, Hamilton and Madison) that house programs, 59.0/100,000 than the rate for those that live 60 miles or more from a program, 32.2/100,000."²⁷

The proposed location is located in the largest city in this service area (Johnson City). It is within 25 minutes or less of the next two largest cities in this area: Kingsport, and Bristol. Today, people from this area suffering from opiate addiction drive hundreds of miles round trip for treatment. Patients are most vulnerable to relapse when they first enter treatment. Patients must attend every day (seven days a week) for the first 45 days of treatment. This places an undue hardship on those seeking treatment. Moreover, for every patient that does travel the distance, several may forego treatment.

The effects of untreated heroin abuse are well documented. According to the New York Academy of Medicine, the lifetime Medicaid cost for each injecting drug user with AIDS is about \$109,000. In contrast, one year of methadone treatment costs about \$5,000 per patient, and is private pay with no drain on public coffers. According to the Tennessee Department of Health, nearly 1,000 new HIV cases are reported each year in the State²⁸.

Untreated addicts commit more crime, are more susceptible to HIV, abandon their families, have higher unemployment and absenteeism, and neglect their overall health significantly more than addicts in treatment. Between 2004 and 2010, opioid- and heroin-related emergency room visits went up three-fold²⁹.

Every dollar invested in opioid dependence treatment may yield a return of between \$4 and \$7 in reduced drug related crime, criminal justice costs, and theft alone. When savings related to health care costs are included, the ratio can equal 12:1 for every dollar invested³⁰. Further, since our program will rely on self-payment, the State will receive the benefits without having to make any financial investment.

Our proposed site removes this barrier to treatment for patients who do not seek treatment and makes it easier for patients in treatment to stay in treatment. This will greatly benefit the Northeast Tennessee Area and the State of Tennessee.

²⁵.Id.

²⁶ Center for Health Care Evaluation and Health Economics Resource Center, Veterans Affairs, Palo Alto Health Care System, Palo Alto, CA, USA. *"The influence of distance on utilization of outpatient mental health aftercare following inpatient substance abuse treatment."*

²⁷ <http://health.state.tn.us/Downloads/g6022004.pdf>

²⁸ <http://health.state.tn.us/statistics/std.htm>

²⁹ SAMHSA

³⁰ Institute of Addiction Medicine.

March 25, 2013

12:15pm

4. A. Describe the demographics of the population to be served by this proposal.

The nine-county demographic summary:

	PROPOSED SERVICE AREA (COUNTIES)									Total for service area	Tennessee
Demographic	Johnson	Carter	Sullivan	Washington	Unicoi	Hawkins	Greene	Hamblen	Cocke		
Population, 2011 estimate	18,231	57,135	157,419	124,353	18,280	56,671	68,339	63,062	35,544	800,084	6,399,767
Population, 2010 (April 1) estimates base	18,244	57,424	156,623	122,979	18,313	56,633	68,631	62,544	35,652	597,653	6,346,113
Population, percent change, April 1, 2010 to July 1, 2011	-0.1%	-0.4%	0.4%	1.1%	-0.2%	-0.3%	0.7%	0.8%	-0.3%	0.4%	0.8%
Persons under 5 years, percent, 2011	4.7%	5.2%	5.1%	5.4%	4.8%	5.3%	5.3%	6.3%	5.6%	5.3%	6.3%
Persons under 18 years, percent, 2011	16.1%	19.9%	20.3%	19.9%	20.0%	21.9%	21.0%	23.5%	21.1%	20.7%	23.3%
Persons 65 years and over, percent, 2011	18.6%	17.4%	19.0%	15.7%	19.9%	17.1%	18.0%	16.2%	17.4%	17.5%	13.7%
Female persons, percent, 2011	46.3%	51.1%	51.6%	51.1%	51.1%	51.0%	51.0%	51.2%	51.6%	51.1%	51.3%
White persons, percent, 2011 (a)	95.4%	86.7%	85.4%	92.6%	98.1%	95.6%	95.0%	91.8%	95.4%	94.8%	79.5%
Black persons, percent, 2011 (a)	2.2%	1.6%	2.4%	4.2%	0.4%	1.6%	2.2%	4.6%	2.2%	2.8%	16.9%
American Indian and Alaska Native persons, percent, 2011 (a)	0.2%	0.2%	0.3%	0.4%	0.4%	0.3%	0.3%	0.7%	0.5%	0.4%	0.4%
Asian persons, percent, 2011 (a)	0.2%	0.3%	0.6%	1.2%	0.2%	0.6%	0.4%	0.8%	0.3%	0.6%	1.5%
Native Hawaiian and Other Pacific Islander persons, percent, 2011 (a)	Z	Z	Z	Z	Z	Z	Z	0.1%	0.1%	0.1%	Z
Persons reporting two or more races, percent, 2011	0.9%	1.2%	1.2%	1.5%	1.0%	1.0%	1.0%	1.7%	1.5%	1.3%	1.6%
Persons of Hispanic or Latino Origin, percent, 2011 (b)	1.6%	1.5%	1.6%	3.0%	4.1%	1.3%	2.6%	11.0%	1.9%	3.1%	4.7%
White persons not Hispanic, percent, 2011	95.0%	95.2%	94.1%	90.0%	94.2%	95.5%	93.6%	82.4%	93.9%	92.2%	75.4%
Living in same house 1 year & over, percent, 2007-2011	89.5%	86.3%	85.8%	82.9%	88.0%	86.1%	86.8%	84.6%	86.8%	85.5%	84.1%
Foreign born persons, percent, 2007-2011	0.7%	0.9%	1.6%	3.4%	3.0%	1.1%	2.1%	7.3%	1.6%	2.5%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	1.8%	1.8%	2.6%	4.6%	5.2%	2.4%	3.9%	10.4%	2.8%	4.0%	6.4%
High school graduate or higher, percent of persons age 25+, 2007-2011	70.1%	78.6%	82.7%	85.1%	75.3%	78.0%	79.2%	78.5%	72.8%	80.4%	83.2%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	10.7%	15.7%	20.4%	28.2%	11.7%	12.4%	14.8%	15.7%	8.1%	18.4%	23.0%
Veterans, 2007-2011	1614	5470	15315	11873	1738	5211	6114	5622	3544	56,489	501,665
Mean travel time to work (minutes), workers age 16+, 2007-2011	26.7	22	20.9	19.8	24.7	24.3	23	21.2	27.6	22.1	24
Per capita money income in the past 12 months (2011 dollars), 2007-2011	\$16,957	\$18,269	\$23,638	\$24,742	\$20,753	\$20,293	\$19,036	\$21,331	\$17,014	\$ 21,555	\$24,197
Median household income, 2007-2011	\$32,159	\$32,148	\$40,572	\$42,104	\$35,265	\$38,795	\$36,310	\$39,604	\$28,563	\$ 38,007	\$43,889
Persons below poverty level, percent, 2007-2011	23.4%	22.0%	16.6%	17.3%	20.7%	18.9%	21.6%	17.7%	26.9%	18.9%	16.9%
Land area in square miles, 2010	298	341	413	326	186	467	622	161	435	3,271	41,234.90
Persons per square mile, 2010	61.1	168.3	379.4	376.7	98.4	116.7	110.6	388	82.1	287.9	153.9
(a) Includes persons reporting only one race.											
(b) Hispanics may be of any race, so also are included in applicable race categories.											
FN: Footnote on this item for this area in place of data											
NA: Not available											
D: Suppressed to avoid disclosure of confidential information											
X: Not applicable											
S: Suppressed, does not meet publication standards											
Z: Value greater than zero but less than half unit of measure shown											
F: Fewer than 100 firms											
Source: US Census Bureau State & County QuickFacts											

This service area represents approximately 10% of Tennessee's population. Compared to the State, this service area has:

- A higher percentage of Caucasians
- Lower average income

Both of these demographic statistics indicate a higher opiate addiction rates:

- Using opioid-related emergency room visits as a marker, Caucasians are 43% more likely than African-Americans to abuse opiates on a per-capita basis.³¹
- The link between poverty and substance abuse is well established, particularly in the

³¹ Center for Behavioral Health Statistics and Quality, SAMHSA

Appalachian region.³²

b. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

The most apparent disparity for our proposed service area is the lack of treatment, as the table below shows. There are 6 Combined Metropolitan Statistical Areas (CMSA) in Tennessee. CMSAs are combinations of Metropolitan and Micropolitan Statistical Areas.

CMSA	POPULATION	Number of NRMTF's
Nashville-Davidson-Murfreesboro-Columbia, TN	1,533,406	2
Memphis	1,274,704	3
Knoxville-Sevierville-La Follette, TN	1,010,978	2
Chattanooga-Cleveland-Athens, TN-GA	658,201	5 ³³
JOHNSON CITY-KINGSPORT-BRISTOL (TRI-CITIES), TN-VA	493,587	0
Jackson-Humboldt, TN	160,398	1
Dyersburg (not a CMSA)	37,886	1
Paris (not a CMSA)	31,837	1
Savannah, TN (not a CMSA)	6,917	1
Total		16

It is impossible to talk about disparities in accessibilities when there are no service providers. For the patients that travel hundreds of miles for treatment, this challenge is exacerbated with poverty, and for the elderly and women who must stay home to take care of a family.

In providing a local treatment option, our proposed facility will remove the most significant barrier to treatment for everyone affected – geographic distance - a barrier that is even greater for the poor, women and elderly.

³² Appalachian Regional Commission Report, 2008

³³ This figure includes one Tennessee NRMTF plus 4 "border play" facilities in Georgia

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

There are no NRMFTF service providers in our proposed service area. Applicant requested Central Registry data to calculate utilization rates of existing NRMFTF's in Tennessee and to learn how many current patients from the proposed service area are using other clinics. Tennessee Department of Mental and Substance Abuse Services informed applicant that it would no longer provide such data because of policy change. The need for the proposed service area has been documented in Sections B1, Section C General Criteria, Need, and in Question 1 of this Section. Our projected utilization is in our response to No. 6 below.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Since our facility would be new, we have no history. We took two approaches to project our utilization. The first was to examine the number of patients from the Northeast Tennessee /service area were in treatment in the nearest clinics (North Carolina and Tennessee), and make estimates on how many would transfer to a center that was 100-200 miles closer round-trip. The second way was to apply per capita statistics on patients in treatment from Tennessee and apply them to our projected service area. Both approaches yield a similar number of projected patients. We averaged the results. Our projected utilization, and associated calculations, assumptions and sources are shown in the table below.

- **Method One: Transfer Method**

End of Year	End of Year Patients	End of Year Facility Utilization	Methodology	Patient assumptions	Utilization assumptions	Source
1	918	51%	50% of the Tri-Cities patients currently traveling to Asheville (1,400) and 80% traveling to Knoxville would transfer; 10% taper off/release	1 shift operation; admissions 3 days per week; variance granted for operating hours	1 counselor per 50 patients; 200 sq. feet of space plus overhead per counselor; 7,000 feet of office space	Ownership of Asheville area clinics; interview with Knoxville Program Directors; CARF, Federal and State regulations
2	1208	69%	25% of Year 1 patients taper off/released; admit 10 new patients per week			Experience owning 9 other clinics

- **Method Two: Tennessee Per-Capita Method**

SECTION C: GENERAL CRITERIA FOR CERTIFICATION OF NEED

48

SUPPLEMENTAL- # 1

March 25, 2013

12:15pm

End of Year	End of Year Patients	End of Year Facility Utilization	Methodology	Patient assumptions	Utilization assumptions	Source
1	850	49%	Use the per-capita rate of admissions (189 per 100,000) from the 2009 Tn State Registry (with projected growth) and apply it to the service area population. Assume 75% of these patients are admitted in the first year.	1 shift operation; admissions 3 days per week; variance granted for operating hours	1 counselor per 50 patients; 200 sq. feet of space plus overhead per counselor; 7,000 feet of office space	Ownership of Asheville area clinics; TN Dept. of Mental Health; interview with Knoxville Program Directors; CARF, Federal and State regulations
2	1134	63%	Remaining 25% of per-capita patients are admitted.			Experience owning 9 other clinics

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

- All projects should have a project cost of at least \$3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)
- The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.
- The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.
- For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.

See pages that follow.

Applicant provides the following footnotes to accompany the Project Cost Chart:

Line A.2. Legal, administrative and consultant fees include CARF accreditation and materials

Line B1. Facility costs include the monthly leasing and common area maintenance fees for a five year lease at an average of \$5,333 per month

Line C4. Includes the operating losses that must be financed during the time between when the facility opens until it becomes cashflow positive.

PROJECT COSTS CHART

SUPPLEMENTAL- # 2

March 28, 2013

9:00 am

A. Construction and equipment acquired by purchase:	
1. Architectural and Engineering Fees	\$25,000
2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	30,000
3. Acquisition of Site	
4. Preparation of Site	160,000
5. Construction Costs	
6. Contingency Fund	
7. Fixed Equipment (Not included in Construction Contract)	
8. Moveable Equipment (List all equipment over \$50,000)	23,500
9. Other (Specify) <u>Office furniture, computers, etc.</u>	20,000
B. Acquisition by gift, donation, or lease:	
1. Facility (inclusive of building and land)	\$320,000
2. Building only	
3. Land only	
4. Equipment (Specify) _____	
5. Other (Specify) <u>Patient software</u>	8,500
C. Financing Costs and Fees:	
1. Interim Financing	
2. Underwriting Costs	
3. Reserve for One Year's Debt Service	
4. Other (Specify) <u>Operating loss carry</u>	\$80,000
D. Estimated Project Cost (A+B+C)	\$667,000
E. CON Filing Fee	\$3,000
F. Total Estimated Project Cost (D+E)	
TOTAL	\$670,000

PROJECTED DATA CHART

2013 MAR 28 AM 10 19

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

	Year 2014_	Year_2015_
A. Utilization Data (Specify unit of measure)	530 avg. pts._	1,056 avg. pts.
B. Revenue from Services to Patients		
1. Inpatient Services	_____	_____
2. Outpatient Services	\$1,782,14__	\$3,903,715
3. Emergency Services	_____	_____
4. Other Operating Revenue (Specify)_____	_____	_____
Gross Operating Revenue	\$1,782,144	\$3,903,715
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	\$_____	\$_____
2. Provision for Charity Care	__35,643	__78,074__
3. Provisions for Bad Debt	__17,821__	__39,037__
Total Deductions	\$_53,464_	\$_117,111_
NET OPERATING REVENUE	\$1,728,680	\$3,786,604_
D. Operating Expenses		
1. Salaries and Wages	\$780,000	\$1,573,135
2. Physician's Salaries and Wages	__144,000__	__144,000__
3. Supplies	__579,750__	__767,972__
4. Taxes	__5,092__	__435,719__
5. Depreciation	__25,000__	__25,000__
6. Rent	__67,200__	__67,200__
7. Interest, other than Capital	_____	_____

2013 MAR 28 AM 10 20

8. Management Fees:		
a. Fees to Affiliates	_____	_____
b. Fees to Non-Affiliates	_____	_____
9. Other Expenses – Specify on Page 32	<u>120,000</u>	<u>120,000</u>
Total Operating Expenses	\$1,721,042	\$3,133,026
E. Other Revenue (Expenses) -- Net (Specify) _____	\$ _____	\$ _____
NET OPERATING INCOME (LOSS)	\$7,638	\$653,578
F. Capital Expenditures		
1. Retirement of Principal	\$ _____	\$80,000
2. Interest	_____	<u>8,000</u>
Total Capital Expenditures	\$ _____	\$88,000
NET OPERATING INCOME (LOSS)		
LESS CAPITAL EXPENDITURES	<u>\$7,638</u>	<u>\$565,578</u>

HISTORICAL DATA CHART-OTHER EXPENSES

2013 MAR 28 AM 10 20

OTHER EXPENSES CATEGORIES

	Year_NA_	Year_NA_	Year_NA_
1.	\$_____	\$_____	\$_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
Total Other Expenses	\$_____	\$_____	\$_____

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES

	Year_2014_	Year_2015
1. Utilities	\$24,000_	\$24,000_
2. Insurance	_54,000_	_54,000
3. Travel and other	_42,000_	_42,000_
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
Total Other Expenses	\$120,000_	\$120,000_

March 25, 2013

12:15pm

2. Identify the funding sources for this project.

Please check the applicable item(s) below and briefly summarize how the project will be financed. *(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)*

- ☐ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;
- ☐ B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;
- ☐ C. General obligation bonds--Copy of resolution from issuing authority or minutes from the appropriate meeting.
- ☐ D. Grants--Notification of intent form for grant application or notice of grant award; or
- ☒ E. Cash Reserves--Appropriate documentation from Chief Financial Officer.
- ☐ F. Other--Identify and document funding from all other sources.

Cash Reserves of the Applicant. See Attachment C, Economic Feasibility-2.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

These costs were developed with the Applicant's experience of having opened 9 NRMTFs in 4 states. In every case, the projects involve standard work elements:

- Adding and modifying offices, including wall construction and moving, adding electrical, phones, cable and security, reconfiguring heating and air conditioning systems, etc.
- Adding workrooms unique to NRMTFs such as dosing windows, pharmacy, and payment/check-in areas
- Outfitting the offices with desks, computers, phones, etc.
- Installing patient and accounting software systems unique to NRMTFs

4. Complete Historical and Projected Data Charts on the following two pages--Do not modify the Charts provided or submit Chart substitutions! Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue

and expense projections for the Proposal Only (i.e., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

See page that follows

Notes to Project Data Chart:

- CARF accreditation and material costs are included in Other Expenses
- Of the 530 patients during the first year, Applicant's assumptions for initial treatment are:
 - Methadone: 73%, or 387
 - Buprenorphine-based treatment: 25%, or 133
 - Abstinence-based treatment: 2%, or 10
- Applicant was asked to provide Historical Data Chart for the last three years for a center in Asheville, NC. Applicant is a currently a shareholder of the company and not an officer or member of management, and as such does not have access to this information.

HISTORICAL DATA CHART

2013 MAR 25 PM 12 07

Give information for the last *three* (3) years for which complete data are available for the facility or agency. The fiscal year begins in _____ (Month).

	Year N/A	Year N/A	Year N/A
A. Utilization Data (Specify unit of measure)			
B. Revenue from Services to Patients			
1. Inpatient Services	\$ _____	\$ _____	\$ _____
2. Outpatient Services	_____	_____	_____
3. Emergency Services	_____	_____	_____
4. Other Operating Revenue (Specify) _____	_____	_____	_____
Gross Operating Revenue	\$ _____	\$ _____	\$ _____
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	\$ _____	\$ _____	\$ _____
2. Provision for Charity Care	_____	_____	_____
3. Provisions for Bad Debt	_____	_____	_____
Total Deductions	\$ _____	\$ _____	\$ _____
NET OPERATING REVENUE	\$ _____	\$ _____	\$ _____
D. Operating Expenses			
1. Salaries and Wages	\$ _____	\$ _____	\$ _____
2. Physician's Salaries and Wages	_____	_____	_____
3. Supplies	_____	_____	_____
4. Taxes	_____	_____	_____
5. Depreciation	_____	_____	_____
6. Rent	_____	_____	_____
7. Interest, other than Capital	_____	_____	_____
8. Other Expenses (Specify) _____	_____	_____	_____
Total Operating Expenses	\$ _____	\$ _____	\$ _____
E. Other Revenue (Expenses) – Net (Specify)	\$ _____	\$ _____	\$ _____
NET OPERATING INCOME (LOSS)	\$ _____	\$ _____	\$ _____
F. Capital Expenditures			
1. Retirement of Principal	\$ _____	\$ _____	\$ _____
2. Interest	_____	_____	_____
Total Capital Expenditures	\$ _____	\$ _____	\$ _____
NET OPERATING INCOME (LOSS)	\$ _____	\$ _____	\$ _____
LESS CAPITAL EXPENDITURES	\$ _____	\$ _____	\$ _____

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

Patients (average during year)	530	1,056
Average gross charge (revenue per year)	\$3,363	\$3,697
Average deduction from operating revenue	\$101	\$111
Average net charge	\$3,262	\$3,586

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Since this is a new operation, Applicant submits planned charges.

Service	Proposed Charge
Intake assessment	\$50
Methadone Fee	\$10 per day
Buprenorphine/Suboxone Fee	\$200 per month plus medication cost
Guest dosing	\$20 per day
Drug screens, passed	\$0, included in medication
Drug screens, failed	\$25
Counseling	\$0, included in fees above
Annual Health & Physical	\$0, included in fees above

6. B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

The comparative charge schedule is shown below:

Service	Charge	Phone survey results, if available
Intake assessment	\$50	Waived at Asheville area clinics, \$50 at Knoxville clinics and Galax, VA; \$25 at Stepping Stone in Boone, NC
Methadone Fee	\$10 per day	\$16.14 at 2 clinics in Knoxville; \$11 – \$13 per day at Asheville clinics and Boone, NC; Galax, VA is \$25 per day according to a 3/22 phone inquiry
Buprenorphine/Suboxone Fee	\$200 per month plus medication cost	Asheville area clinics were full and not accepting new patients; Stepping Stone is \$13-\$21 per day depending on dosage; Galax, VA is \$30 per day. \$400 per month plus medication cost at buprenorphine-private physician offices, without counseling, drug testing, STD/HIV/TB testing, diversion control, etc.
Guest dosing	\$20 per day	\$15 - \$25 per day plus a one-time charge of \$25

Drug screens, passed	\$0, included in medication	\$0, included in medication
Drug screens, failed	\$25	\$0 - \$25
Counseling	\$0, included in fees above	\$0, included in fees above at other NRMFTs Either not available or on a referral basis at buprenorphine-approved private physician offices
Annual Health & Physical	\$0, included in fees above	\$0, included in fees above

This is a new project, so there is no impact to previous charge schedules.

Based upon telephone surveys in February 2013, the proposed gross charge is approximately 20%-33% less than those charged by the nearest clinics in North Carolina and Tennessee (Crossroads in Weaverville, NC and DRD in Knoxville, TN). Based on phone interviews during March, 2013, the clinics in Knoxville charged approximately \$16.30 per day and the clinics in Weaverville and Asheville, NC charge between \$12 and \$13 per day.

Since TennCare does not cover Methadone Clinic Services³⁴ for patients over 21 years of age and Medicare does not pay for methadone maintenance treatment, there is not a relevant comparable charge base.

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

This project is scheduled to be cash flow positive within 180 days of opening. Any negative variances to this will be covered by Tri-Cities Holdings, LLC.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

As shown in the Projected Data Chart, this project is projected to be cash flow positive in Year 1, and ongoing thereafter. The management of Tri-Cities Holdings, LLC has opened 9 similar NRMFTs in four states and has significant experience and an excellent track record of ensuring cash flow positive, viable and compliance NRMFTs. In the supporting document, a personal financial

³⁴ www.tn.gov/tenncare/forms/phar20050912.pdf

statement is included in Attachment C Economic Feasibility-10 for Steve Kester, Tri-Cities Holding's CEO, who will personally guarantee this project through fruition. All funds required to open and outfit this facility, and cover the operating loss during the first year, plus contingency, are secured.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

The Applicant plans to utilize self-pay programs and does not plan to participate in State and federal programs such as TennCare or Medicare. If the healthcare environment shifts, such as universal coverage of NRMFTs services for qualified patients, the Applicant may revisit this decision. Because buprenorphine patients will comprise an estimated 25% of applicant's patient mix, the applicant cannot justify the investment of resources required to maintain compliance with TennCare. However, a call to TennCare Solutions (888-816-1680) indicated that TennCare patients can be reimbursed for approved medication and services upon individual submission of receipts.

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

The proposed facility and the company are new, so no historical data is available. Personal financial statements are included in Attachment C Economic Feasibility-10 for Tri-Cities Holding's CEO who is personally funding and guaranteeing this project.

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

There is no treatment in the proposed service area currently. Our proposal may appear to be more expensive than the status quo, i.e. no service. However, the State of Tennessee and many organizations have documented the cost of untreated persons significantly outweigh the cost of treatment, as measured by crime, broken families, loss or diminishment of employment, related health costs, and fatalities³⁵.

³⁵ tn.gov/mental/policy/presc_drug_abuse.shtml

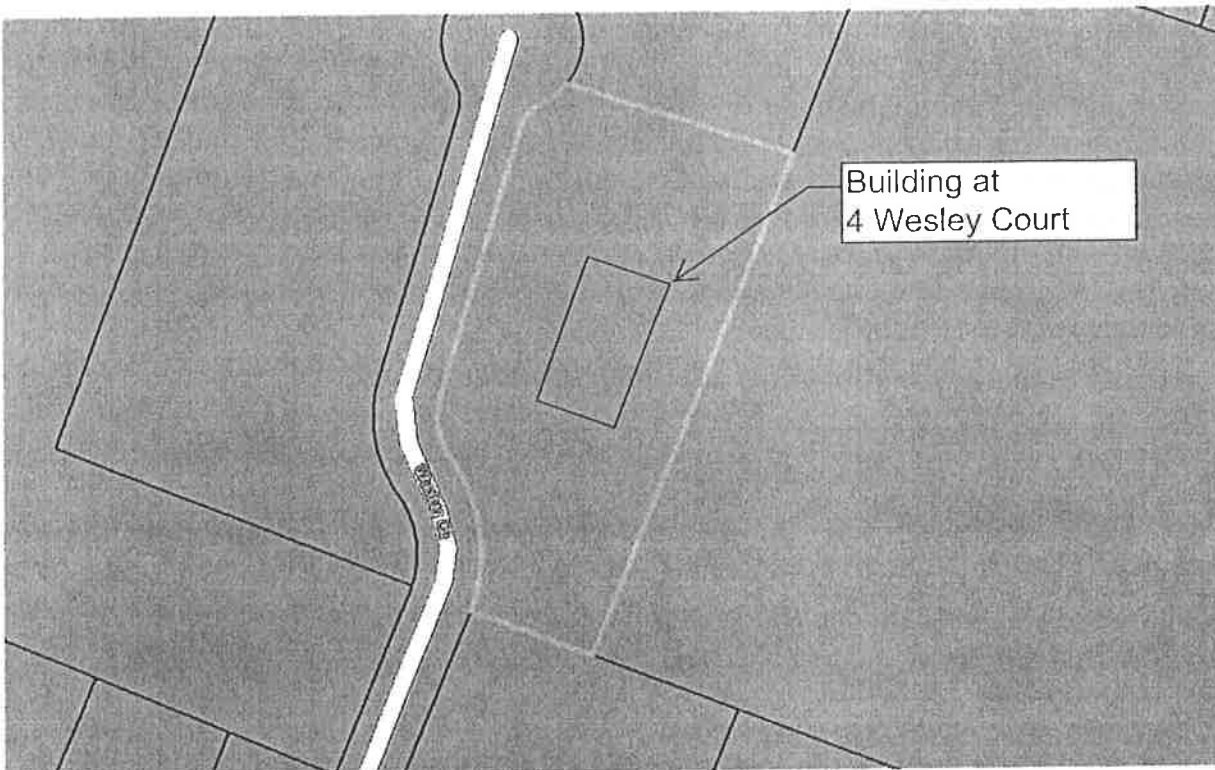
PLOT PLAN

Washington County - Parcel: 038B B 006.00⁶¹

SUPPLEMENTAL- # 1

March 25, 2013

12:15pm



Date Created: 3/18/2013

1. Parcel size: 1.66 acres
2. Building size: 8,208 square feet
3. All construction will be inside the four exterior walls of the building.
4. Names of streets, roads or highway that cross or border the site: Wesley Court

As for effectiveness of treatment, methadone maintenance treatment has proven the most effective treatment for opiate addiction, as studied by numerous agencies, including the Centers For Disease Control and the National Institute on Drug Abuse³⁶. However, our proposed services also include buprenorphine-based treatment and abstinence-based services. The patient, together with his or her care team of doctors, nurses and counselors will decide the best treatment plan. In addition, we anticipate that patients will migrate between treatment services. For example, a patient may be stabilized with methadone, tapered down and switched to Suboxone, then transition to abstinence-based treatment, and finally be discharged after successfully demonstrating the ability to live independently without relapse.

Our estimate is that *initial* treatments will breakdown as follows:

- Methadone maintenance: 73%
- Buprenorphine-based treatment: 25%
- Abstinence treatment: 2%

Comparison of applicant's proposed services and inpatient treatment:

- Frontier Health/Magnolia Ridge Alcohol & Drug Residential Treatment
900 Buffalo Street
Johnson City, TN 37604
www.frontierhealth.org
COST: \$6,000 per month (compared to applicant's \$400/month outpatient)
NOTE: 9-12 week waiting list.
- Comprehensive Community Services
6145 Temple Star Road
Kingsport, TN 37660
ccstreatment.com
COST: \$5,600 per month (compared to applicant's \$400/month outpatient)
NOTE: 100+ patients on waiting list/Minimum four weeks until available.

b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

The applicant reviewed more than 50 locations in the Tri-Cities area before selecting its proposed location. Beyond best meeting zoning requirements, the proposed facility was chosen because it was located in the biggest city of the proposed service area and therefore close to the maximum number of anticipated patients; it had ready highway access to all points within the proposed service area; and it required no new construction, only upfitting and modifications to an existing structure. Tri-Cities Holdings has balanced cost control with providing patients quality care and a healing environment.

³⁶ www.cdc.gov/idu/facts/methadonefin.pdf

ORDERLY DEVELOPMENT

1. List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

The applicant intends to have transfer relationships with all emergency hospitals in the Tri-Cities and surrounding area, including the Johnson City Medical Center and Wellmont Urgent Care; in Kingsport: Holston Valley Medical Center and Indian Path Primary Care; in Bristol: Bristol Regional; Union County Memorial in Erwin; Laughlin Memorial in Greeneville and Hawkins County Memorial in Rogersville.

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

This project will significantly improve the lives and financial well being to those people suffering from opiate addictions that cannot or will not drive hundreds of miles for the nearest treatment. In doing so, the communities of the proposed service area will benefit from less crime, more families intact, less work truancy, and less rates of HIV and hepatitis infections.

For those patients domiciled in the proposed service area who currently travel hundreds of miles for treatment, our proposed facility will help their finances (approximately \$30 per day of treatment), allow them to spend more time with their families, seek new or better employment, and help keep them from relapsing.

Because of the epidemic levels of drug overdose deaths and prescribed pain medicine, Tennessee providers have experienced significant increases in enrollment³⁷, so this project is not expected to have any negative consequences to the current base of providers.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

Our proposed facility will pay competitive wage and benefit packages for our staff. The staffing

³⁷ CDC reports overdose deaths have tripled since 1990 in <http://www.cdc.gov/homeandrecreationalsafety/rxbrief/> and Tennessee reports a 250% increase from 2001 – 2010, the percentage of people identifying prescription opioids as their primary substance of abuse increased from 5% in 1999 to 23% in 2009 in http://tn.gov/mental/policy/persc_drug_docs/Prescription%20Drug%20Use%20in%20TN_2%203%202012_R2.pdf

levels and compensation levels are shown in the table below³⁸, ranked in the order of the number of staff patient care positions. This data was aided by the Tennessee Department of Labor and Workforce Development, 2012 Occupation Wage Report for the Johnson City Healthcare Industry. The compensation figures below are in-line with the Tennessee statistics.

Position	Average number of fulltime staff, Year 1	Average number of fulltime staff, Year 2	Annual compensation Range, Entry - Senior	Tennessee Dept of Labor Range ³⁹
Substance Abuse Counselors	12	22	\$22,000 - \$30,000	\$25,661 – \$34,666
LPN Dosing Nurses	2	4	\$27,000 - \$37,000	\$27,512- \$37,268
Charge Nurse	1	1	\$45,000 - \$55,000	\$39,678- \$64,293
Charge Counselor	1	1	\$35,000 - \$40,000	\$31,651- \$34,646
Program Director	1	1	\$70,000 - \$110,000	\$78,220- \$99,889
Medical Director	Contract (part time)	Contract (part time)	\$150,000 - \$200,000	\$137,042- \$225,926

A Security Guard is currently not planned. If the need arises, this position will be hired.

All personnel will satisfy State MINIMUM PROGRAM REQUIREMENTS FOR NON-RESIDENTIAL OPIOID TREATMENT PROGRAM FACILITIES, Staff Qualifications, Rule 0940-05-42-.29

Applicant has interviewed candidates for the Medical Director and a Program Director positions. Current candidates meet certification requirements. Because of the uncertainty with respect to approval and timing, offers cannot be extended and candidates do not wish to be identified.

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

The applicant operates nine other facilities in four states and is aware of the difficulty of hiring in the healthcare market.

³⁸ <http://www.tn.gov/labor-wfd/wages/2012/PAGE0144.HTM>

³⁹ TN Dept of Labor & Workforce Dev, Div Emp Sec, R&S.

The applicant is aware of the licensing requirements of the State, including the staffing requirements.

Fortunately, Johnson City is home to one of the Country's best universities for nursing, medicine and social work: East Tennessee State University. In addition, the area has a vibrant medical community from which to recruit entry level and experienced professionals.

Hiring and keeping the right staff is always a challenge and the applicant is experienced and financed ready to meet the challenges.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.

The applicant verifies this.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

The applicant has significant experience working developing internships and other partnerships with local universities and professional societies. Applicant looks forward to establishing these ties with ETSU's undergraduate and graduate healthcare programs and Northeast State Community College's Social Work (A.A. Degree) program.

Internships and other partnerships must take into account the confidentiality, and sensitivity of the nature of a clinic of this type.

7. (a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

The applicant verifies this.

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

LICENSURE: Department of Mental Health and Substance Abuse Services, Office of Licensure

CERTIFICATION: Federal Certification from U.S. Health And Human Services, Division of Substance Abuse and Mental Health Services Administration (SAMHSA)

ACCREDITATION: Commission on Accreditation of Rehabilitation Facilities (CARF)

March 25, 2013

12:15pm

(c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

Not Applicable (NA).

(d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

Not Applicable (NA). Applicant was asked to provide health survey results for centers in North Carolina. Applicant is a shareholder of the company that operates these centers, but is not an officer or member of management. As such, he has no access to these records.

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

None.

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project.

None.

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.

Yes, subject to Federal HIPAA regulation

PROOF OF PUBLICATION

March 25, 2013

12:15pm

JOHNSON CITY PRESS

204 W. Main St., Johnson City, TN 37604

AFFIDAVIT OF PUBLICATION

AD# 1065011
DATE: 3-6-2013

STATE OF TENNESSEE

WASHINGTON COUNTY SS

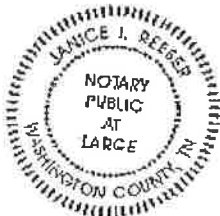
Richard Clark makes the oath that he is the Vice President of Advertising Inside Sales

of the JOHNSON CITY PRESS, a daily newspaper published in Johnson City, in said County and State, and
that the advertisement was published in said newspaper for three (3) insertion(s) commencing on3-6-2013 and ending on 3-6-2013

Signature

Sworn to and subscribed before me this 03 07 2013
Month Day Year

In testimony whereof I have hereunto set my hand and seal this third day and year aforesaid.



JAN REESER

Notary Public

My commission expires: 03/02/2016

2013 MAR 25 PM 12 07

**NOTIFICATION OF INTENT TO APPLY FOR A
CERTIFICATE OF NEED**

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that: Tri-Cities Holding LLC, with an ownership type of Limited Liability Company and to be managed by: Manager Steve Kester intends to file an application for a Certificate of Need Establishment of non-residential substitution-based treatment center for opiate addiction offering methadone and buprenorphine which is designed to treat opiate addiction by preventing symptoms of withdrawal. In addition, we will offer individual counseling services and group therapy to help break the cycle of addiction and provide patients the life skills and resources to serve as productive members of their communities, families and employers. The location of the proposed project is 4 Wesley Court, Johnson City, Tennessee 37601. The project cost is estimated to be \$ 670,000.

The anticipated date of filing the application is: March 7, 2013.

The contact person for this project is Steve Kester, Manager who may be reached at: Tri-Cities Holdings LLC 6555 Sugarloaf Parkway Suite 307-137 Duluth Georgia 30097 404-664-2616. Upon written request by interested parties, an local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
The Frost Building Third Floor
161 Rosa L Parks Boulevard
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than Fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.
2. If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph*, please state below any request for an extended schedule and document the "good cause" for such an extension.

PROJECT COMPLETION FORECAST CHART

March 25, 2013

12:15pm

Enter the Agency projected Initial Decision date, as published in the C.A. § 68-11-1609(c): 6/13
 2013 March 25 PA 12 07

Assuming the CON approval becomes the final agency action on that date; indicate the number of days from the above agency decision date to each phase of the completion forecast.

<u>Phase</u>	<u>DAYS REQUIRED</u>	<u>Anticipated Date (MONTH/YEAR)</u>
1. <u>Architectural and engineering contract signed</u>	0	6/13
2. <u>Construction documents approved by the Tennessee Department of Health</u>	60	8/13
3. <u>Construction contract signed</u>	10	6/13
4. <u>Building permit secured</u>	15	6/13
5. <u>Site preparation completed</u>	N/A	N/A
6. <u>Building construction commenced</u>	20	7/13
7. <u>Construction 40% complete</u>	50	9/13
8. <u>Construction 80% complete</u>	70	10/13
9. <u>Construction 100% complete (approved for occupancy)</u>	90	11/13
10. <u>*Issuance of license</u>	150	1/14
11. <u>*Initiation of service</u>	180	2/14
12. <u>Final Architectural Certification of Payment</u>	210	3/14
13. <u>Final Project Report Form (HF0055)</u>	270	5/14

* For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

TABLE OF ATTACHMENTS

Attachment A.4. Applicant Ownership Structure	52
Attachment A.6. Option to Lease Building	55
Attachment A.3 Operating Agreement and Certificate of Corporate Existence	74
Attachment A.4 Corporate Charter	87
Attachment A. 5 Resumes	89
Attachment B1 Supplemental Questions and Responses	91
Attachment B1 Local Providers	101
Attachment B1-List of Buprenorphine-Certified Private Physicians	102
Attachment B, Project Description, Item III. A. (Plot Plan)	105
Attachment B, Projection Description, Item III. A (Zoning Regulations)	106
Attachment B4 Referral Services	110
Attachment C, Need, 1a. (2008 Tennessee Department of Mental Health Registry Data)	110A-G
Attachment C, Economic Feasibility, 3. (Construction Cost Estimate)	111
Attachment C, Economic Feasibility, Item 2. (Funding Sources)	113
Attachment C, Economic Feasibility 10. Financial Statements	115
Attachment C, Need, Item 3. Proposed Service Area	118
Letters of Support (To Date)	122
Notification Requirement	130

ATTACHMENTS

Applicant Ownership Structure Attachment A.4.

Information for Section A, Item 4: Tri-Cities Holdings Ownership

Name	Title	Membership Interest	Address
Steven W. Kester	Manager	50%	2892 Darlington Run Duluth, GA 30097
Leigh B. Dunlap	Member	50%	801 West Conway Drive NW, Atlanta, Georgia 30327

Attachment A-5

Management Biographies and Affiliations

Tri-Cities Holdings, LLC is owned equally between Steven W. Kester and Leigh B. Dunlap.

Steve Kester is 49 years old and a unit holder of Tri-Cities Holdings, and serves as the company's Chief Executive Officer.

Mr. Kester was the co-founder of Treatment Centers HoldCo, doing business as Crossroads Treatment Centers. He is currently a minority shareholder of Treatment Centers HoldCo and not active in the management of the company. The company operates 9 centers in the following states and cities: North Carolina: Asheville, Weaverville, and Greensboro; South Carolina: Greenville, Columbia and Seneca; Georgia: Ringgold and Suwanee; and Virginia: Danville.

Mr. Kester has spent his career building companies in healthcare, service industries, and consumer products.

Mr. Kester holds an MBA from the Wharton School and an Electrical Engineering Degree from Georgia Tech.

Mr. Kester is married with three children.

* * *

Leigh B. Dunlap attended the University of Southern California (1983-1987).

She has resided in Georgia for the past twenty years.

She is a professional screenplay writer.

She now serves in a volunteer position as president of the Georgia environmental non-profit advocacy group, Clean Earth Now, Inc.

Leigh B. Dunlap is a unit holder of Tri-Cities Holdings LLC and occupies no management position in the company.

**ATTACHMENT B I.
SUPPLEMENTAL QUESTIONS
AND RESPONSES**

Please clarify if Buprenorphine or Methadone will be prescribed for pain management, by a mid-level practitioners, or for the treatment of depression.

No. Our proposed services are for the exclusive treatment of opioid addiction.

What is the difference between Buprenorphine and Methadone in the treatment of opioid addiction? In your response, please discuss the method of administration, frequency, side effects, cost, etc.

The Drug Addiction Treatment Act (DATA) of 2000 allows qualified physicians who obtain a waiver from the federal government to prescribe and dispense two formulations of buprenorphine (subutex and suboxone) to treat opiate addiction. The SAMSHA (Substance Abuse and Mental Health Services Administration) Buprenorphine Physician and Treatment Program Locator web-site list thirty-two (32) physicians that are certified to dispense Buprenorphine in Johnson City, TN. Please discuss the waiver in terms of the training required by private physicians and facilities, the maximum caseloads, etc. In your response, please discuss if these physicians accept cash only from patients (including TennCare patients).

Methadone maintenance treatment (MMT) is the most common and established form of opioid addiction treatment. It was developed in 1964 and has been used continuously since in the United States. In October 2002, the Food and Drug Administration (FDA) approved buprenorphine monotherapy product, Subutex®, and a buprenorphine/naloxone combination product, Suboxone®, for use in opioid addiction treatment. Still, other practitioners believe in abstinence-based treatment.

We believe the answer is that there is no single approach or medication that is right for everybody.

Opioid addiction medications and treatment continue to evolve. Our proposed services will include methadone, buprenorphine, and abstinence-based services. As new medications and treatment approaches come on the market, we will evaluate them. All patients are unique and different medications (or lack thereof) will be evaluated and customized care plans will be developed for each patient. Our pledge is to provide the best option for patients.

The biggest difference between the two is that buprenorphine is a *partial opiate agonist* (i.e. its effects are limited even when taken in large doses) but methadone is a full opiate agonist. The general (not absolute) implications of this are the following:

- Buprenorphine is harder to abuse so patients are more often allowed to take it home. Methadone can be more easily abused, so when patients first start treatment they need to travel to a clinic each day to take their medication. At

later stages of the treatment they are allowed take-home doses of methadone.

- For people with heavy opiate habits and serious addiction, buprenorphine cannot provide effective relief from withdrawal symptoms. Methadone works better for such individuals.
- Buprenorphine is generally less addictive than methadone.
- Withdrawal symptoms of a buprenorphine detox are generally less severe than methadone detox.
- The risk of a fatal overdose on buprenorphine is less than with methadone.

The Drug Addiction Treatment Act of 2000 (DATA 2000)

This act enables *qualifying physicians* to receive a *waiver* from the special registration requirements in the Controlled Substances Act for the provision of medication-assisted opioid therapy. This waiver allows qualifying physicians to practice medication-assisted opioid addiction therapy with Schedule III, IV, or V narcotic medications specifically approved by the **Food and Drug Administration (FDA)**. On October 8, 2002 Subutex® (buprenorphine hydrochloride) and Suboxone® tablets (buprenorphine hydrochloride and naloxone hydrochloride) received FDA approval for the treatment of opioid addiction.

To receive a waiver to practice opioid addiction therapy with approved Schedule III, IV, or V narcotics a physician must notify the **Center for Substance Abuse Treatment (CSAT, a component of the Substance Abuse and Mental Health Services Administration)** of his or her intent to begin dispensing or prescribing this treatment. This Notification of Intent must be submitted to CSAT before the initial dispensing or prescribing of opioid therapy. The "waiver notification" section on this Site provides information on how to obtain and submit a Notification of Intent form. The Notification of Intent can be submitted on-line from this Web site, or via ground mail or fax.

The Notification of Intent must contain information on the physician's qualifying credentials (as defined below) and additional certifications including that the physician has the capacity to refer such addiction therapy patients for appropriate counseling and other non-pharmacologic therapies, and that the physician will not have more than 30 patients on such addiction therapy at any one time for the first year. (Note: The 30-patient limit is not affected by the number of a physician's practice locations. One year after the date on which the physician submitted the initial notification, the physician will be able to submit a second notification stating the need and intent to treat up to 100 patients.)

The Drug Enforcement Administration (DEA)

The Drug Enforcement Administration (DEA) assigns the physician a special identification number. DEA regulations require this ID number to be included on all buprenorphine prescriptions for opioid addiction therapy, along with the physician's regular DEA registration number.

To qualify for a waiver under DATA 2000 a licensed physician (MD or DO) must meet any one or more of the following criteria:

- The physician holds a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties.
- The physician holds an addiction certification from the American Society of Addiction Medicine.
- The physician holds a subspecialty board certification in addiction medicine from the American Osteopathic Association.
- The physician has, with respect to the treatment and management of opioid-addicted patients, completed not less than eight hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that is provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or any other organization that the Secretary determines is appropriate for purposes of this subclause.
- The physician has participated as an investigator in one or more clinical trials leading to the approval of a narcotic drug in schedule III, IV, or V for maintenance or detoxification treatment, as demonstrated by a statement submitted to the Secretary by the sponsor of such approved drug.
- The physician has such other training or experience as the State medical licensing board (of the State in which the physician will provide maintenance or detoxification treatment) considers to demonstrate the ability of the physician to treat and manage opioid-addicted patients.
- The physician has such other training or experience as the Secretary considers to demonstrate the ability of the physician to treat and manage opioid-addicted patients. Any criteria of the Secretary under this subclause shall be established by regulation. Any such criteria are effective only for 3 years after the date on which the criteria are promulgated, but may be extended for such additional discrete 3-year periods as the Secretary considers appropriate for purposes of this subclause. Such an extension of criteria may only be effectuated through a statement published in the Federal Register by the Secretary during the 30-day period preceding the end of the 3-year period involved.

Some, but not all, of the DATA2000 private physicians accepted TennCare. Of those that did not accept TennCare, some took private insurance, and others accepted self-pay methods only.

Please explain what the controlled Substances Database is and how it relates to the proposed project.

The CSMD (Controlled Substance Monitoring Database) was created by an act of the Tennessee legislature, to be administratively attached to the Tennessee Board of Pharmacy. The state statute that covers this database and its use is TCA 53-10-Part 3, Controlled Substance Monitoring Act of 2002. The Board of Pharmacy and the CSMD Advisory Committee establish, administer, maintain and direct the functioning of the database in accordance with this Part 3.

Pharmacies within the state of Tennessee are required to upload all schedule II-V prescriptions at least twice monthly¹.

¹ <https://health.state.tn.us/boards/Controlledsubstance/index.shtml>

For this project, this database was developed to ensure that NRMTF patients are not receiving medication from multiple NRMTFs, to help eliminate the possibility of abuse/overdose of methadone and/or buprenorphine.

Please discuss alternative treatment options available in the community for opioid addiction. Please discuss the drug naltrexone for the treatment of opioid dependence. Please include in your response who can prescribe naltrexone and the oral daily form and the monthly injectable extended-released form (Vivitrol). Is Naltrexone available as treatment option in the proposed service area?

There are no NRMTFs in the proposed service area. NRMTFs are the most common and established treatment options for opioid addiction in the U.S. There are 1,076 of these centers in the United States² and 12 in Tennessee³.

The two most common alternatives to NRMTFs are buprenorphine-based treatment in private physician offices and behavioral therapies, such as abstinence-based treatment available in counseling centers. These options are generally available throughout the U.S., including Tennessee and the proposed service area.

NRMTFs are the most widely used treatment because they are the most successful and the most cost-effective when the scope of medications and services is accounted for.

It is illegal in the United States for a doctor to prescribe methadone for the purposes of treating addiction, unless he or she is working at an appropriately licensed NRMTF. Private physicians rarely offer counseling. Getting buprenorphine at a physician's office is often termed "dose and dash" because of the lack of counseling, drug testing, diversion monitoring, care planning, etc.

Abstinence-based therapies fail 92% of the time⁴ because of the intense hardship and side effects of opiate withdrawal. This is true for heroin users and many prescription pain pill users because the potency of prescription pain pills can match that of heroin. Using Morphine as the standard, the following drugs and their dosages injection are equal to getting the same amount of pain relief as 10 mgs of Morphine injection⁵:

1.5 mg hydromorphone (Dilaudid).....= 10 mg morphine

10 mg methadone (Dolophine).....= 10 mg morphine

² <http://findtreatment.samhsa.gov/TreatmentLocator/faces/servicesSearch.jspx>

³ http://tn.gov/mental/A&D/A_D_docs/methadonelabeledclinics.pdf

⁴

http://www.kap.samhsa.gov/products/trainingcurriculums/pdfs/tip43_curriculum.pdf

⁵ <http://www.adhesions.org/forums/ADHESIONS.0002/0311.html>

15 mg oxycodone (percocet, tylox).....= 10 mg morphine

2 mg levorphanol (Levo-Dromoran).....= 10 mg morphine

1 mg oxymorphone (Numorphan).....= 10 mg morphine

5 mg Heroin.....= 10 mg morphine

75 mg meperidine (demerol).....= 10 mg morphine

130 mg codeine.....= 10 mg morphine

25 ug/hr Fentanyl.....= 10 mg morphine

Naltrexone is a non-opioid medication that is approved for the treatment of opioid dependence. Naltrexone is an opioid receptor antagonist; it binds to opioid receptors, but instead of activating the receptors, it effectively blocks them. Through this action, it prevents opioid receptors from being activated by agonist compounds, such as heroin or prescription pain killers, and is reported to reduce craving and prevent relapse. As opposed to other medications used for opioid dependence (methadone and buprenorphine), naltrexone can be prescribed by any individual who is licensed to prescribe medicine (e.g., physician, doctor of osteopathic medicine, physician assistant, and nurse practitioner), so it is available in the proposed service area. Both the oral daily form and the monthly injectable monthly extended-release form (Vivitrol®) are FDA approved for treatment of opioid dependence. Vivitrol® was approved by FDA for this indication in 2010⁶.

In summary Naltrexone-based therapy is generally accepted for those that have overcome their addiction to opioids because it removes the reward (high) associated with opioids. However, the treatment generally does not adequately address the withdraw symptoms that addicts need.

Please discuss the percentage of patients who have become completely drug free from methadone for significant periods of time.

Patients who are most successful in medication-assisted treatment (MAT) with methadone stay in treatment for more than a year. Many patients need to continue treatment indefinitely, as is the case with any chronic medical condition.

Patients who stay in MAT with methadone for less than three months usually show little or no continued improvement. After several months in treatment, patients are stabilized on methadone. At that point, the use of illegal opioids drops by up to 80%. But leaving treatment after that carries substantial risks. Almost all patients who leave MAT and do not have further treatment of some sort eventually relapse, and risk having an overdose⁷.

⁶ <http://www.dpt.samhsa.gov/medications/naltrexone.aspx>

⁷ Brown LS, et al. the interrelationships between length of stay, methadone dosage, and age at an urban opioid treatment program. Paper presented at: CPDD (College on Problems of Drug Dependence) 65th Annual Meeting; June 2004

Please list the location of methadone anonymous meetings in the applicant's service area. Please indicate if methadone anonymous meetings are planned in the proposed project service area.

A search of <http://www.methadoneanonymous.org/> and <http://www.methadonesupport.org/> showed no locations in the proposed service area. The Applicant pledges to work with patients towards their ultimate independence from addiction and associated treatment programs, including developing and supporting groups that aid in lifetime addiction recovery. Most people who seek MMT treatment got there by abusing opiates for years. Undoing the damage and giving patients the life skills to cope is not fast and is not easy.

The applicant notes prescription medication abuse is higher in the Appalachian region than the rest of the United States. Please provide statistical information related to this statement.

An excellent article was written on this very topic: "Prescription Drug Abuse and the Pill Pipeline in Appalachia", by Dr. Robert Pack. Dr. Pack is associate professor of community health and associate dean for academic affairs at East Tennessee State University's College of Public Health in Johnson City, TN. His report also references the Appalachian Regional Commission's 2008 study of drug use in the Appalachian Region.

The report showed that the Southern Appalachian Region, which includes the proposed service area, the misuse of prescription pain pills was 6.2% versus 5.9% outside of the Appalachian Region.

What type of activities/meetings has your organization conducted to prepare and educate the public in the service area regarding this proposed application?

The Applicant has talked to approximately 50 members of the community while looking for sites that best meet the facility and community needs. These include potential landlords, realtors, brokers, neighboring businesses, etc.

The applicant has talked to, or attempted to contact all local mayors, senators, emergency room leaders, and zoning officials.

The applicant has meet with three news outlets (one news paper and 2 TV stations) and has written editorials and conducted multiple interviews.

The applicant talked at length with Dr. Robert Pack, East Tennessee State University Professor in Johnson City, TN and author of, "Prescription Drug Abuse and the *Pill Pipeline in Appalachia*"

The applicant has talked to 4 faith-based organizations, and the VFW.

What will be the scheduled hours of the proposed methadone facility?

The initial proposed hours of operations will be 5:00 AM until noon seven days per week. It is anticipated that when the facility reaches approximately 500 patients, an afternoon program will be added from noon until 5PM.

March 25, 2013
12:15pm

In-Patient Treatment Programs

	Taking New Patients	TennCare?	Cost/Month	Counseling?	Frequency
Frontier Health/Magnolia Ridge 900 Buffalo Street Johnson City, TN 37604 www.frontierhealth.org	9-12 week waiting list.	Yes	\$6,000	Yes	\$200/Day
Comprehensive Community Services 6145 Temple Star Road Kingsport, TN 37660 ccstreatment.com	100+ waiting list/Minimum four weeks until available.	Yes	\$5,600	Yes	\$200/Day

Buprenorphine-Certified Johnson City-Based Private Physicians

Provider	Number	Accepting Patients?	TennCare?	Cost/Month	Waiting list?	Licensed counseling services?	How often must come?
Stephen R. Cirelli, M.D. Watauga Medical Care 501 East Watauga Avenue Johnson City, TN 37601	(423) 722-8446	No					
David Lionel Forester, M.D. 209 East Unaka Avenue Johnson City, TN 37601	(423) 434-4677	No					
Stephen R. Cirelli, M.D. Medical Care Clinic 105 Broyles Drive Johnson City, TN 37601	(423) 722-4000	Yes	No	\$355	No	No	Monthly
Jose L. Lopez-Romero 100 West Unaka Avenue Suite 4 Johnson City, TN 37601	(423) 928-1393	Yes	No	\$400	No	No	Monthly
Jack A. Norden, M.D. 2406 Susannah Street Johnson City, TN 37601	(423) 262-8633	No*					
Wayne P. Gilbert, M.D. Watauga Family Practice 501 East Watauga Ave. Johnson City, TN 37601	(423) 722-8446	No					
Aubrey Doyce McElroy, Jr. 3201 Bristol Highway Suite 4	(423) 262-8132	Yes	No	\$400	No	No	Monthly

March 23, 2017 12:15pm

Johnson City, TN 37601									
Edward Herschel Crutchfield, M.D.	(423) 946-3199	Not a Working Line							
105 Broyles Street									
Johnson City, TN 37601									
Michael Sanders Wysor, M.D	(423) 722-4000	Yes	No	\$355	No	No	Monthly		
Medical Care Walk In Clinic									
105 Broyles Drive, Suite B									
Johnson City, TN 37601									
Matthew Morgan Gangwer, M.D	(706) 244-1390	Left Message/Not an Office/Not a Local Number (Toccoa, GA number)							
401 East Main Street									
Suite 3									
Johnson City, TN 37601									
Stephen Douglas Loyd, M.D.	(423) 631-0732	No*							
205 High Point Drive									
Johnson City, TN 37601									
Christine Anne Carrejo, M.D.	(423) 722-8446	No							
Watauga Family Practice									
501 East Watauga Avenue									
Johnson City, TN 37601									
Christine Anne Carrejo, M.D.	(423) 929-2584	No Drug Treatment Services--Referred Out to Another Doctor							
401 East Main Street									
Johnson City, TN 37601									
Laura Vanini Grobovsky, M.D	(423) 722-8446	No							
501 East Watauga Avenue									
Johnson City, TN 37601									
Martin P. Eason, M.D.	(423) 631-0432	Yes	No	\$400	No	Yes	Monthly		
3114 Browns Mill Road									
Johnson City, TN 37604									
Tracy Harrison Goen, M.D.	(423) 631-0432	Yes	No	\$400	No	Yes	Monthly		
3114 Browns Mill Road									
Johnson City, TN 37604									
Ray Wallace Mettetal, Jr., M.D	(423) 631-0432	Yes	No	\$400	No	Yes	Monthly		
4113 Browns Mill Road									
Johnson City, TN 37604									
Navneet Gupta, M.D.	(423) 232-6120	No Drug Treatment Services							
101 Med Tech Parkway									
Suite 200									
Johnson City, TN 37604									
William Alan Walker, M.D.	(423) 612-1950	No Drug Treatment Services--Referred Out to Another Doctor							
206 West Holston Avenue									
Johnson City, TN 37604									
Michael Dandridge Tino, M.D.	(423) 928-1393	Yes	No	\$400	No	No	Monthly		
Doctors Assisted Wellness									
100 West Unaka Avenue, Suite #3,4,5									

12:15pm

Johnson City, TN 37604							
Edgar Alan Ongtengco, M.D.	(423) 833-5547	No Drug Treatment Services--Referred Out to Another Doctor					
2514 Wesley Street							
Suite 101							
Johnson City, TN 37604							
Robert David Reeves, M.D.	(423) 282-3379	Yes	No	\$400	No	No	Monthly
926 West Oakland Avenue							
Suite 222							
Johnson City, TN 37604							
Jack R. Woodside, Jr., M.D.	(423) 439-6464	No Drug Treatment Services					
917 West Walnut Street							
Johnson City, TN 37604							
Hetal K. Brahmbhatt, M.D.	(423) 975-5444	Line Disconnected					
500 Longview Drive							
Johnson City, TN 37604							
John McClellan Miller, M.D.	(423) 282-5381	Closed					
811 Wedgewood Road							
Johnson City, TN 37604							
Morgan Counseling Services	(423) 833-5547	No Drug Treatment Services--Referred Out to Another Doctor					
412 West Unaka Street							
Johnson City, TN 37604							
Ralph Thomas Reach	(423) 631-0432	Yes	No	\$400	No	Yes	Monthly
3114 Browns Mill Road							
Johnson City, TN 37604							
LeRoy Robert Osborne, D.O.	(423) 676-9015	Yes	No	\$400	No	No	Monthly
Morgan Counseling & Accociates							
214 West Unaka Avenue							
Johnson City, TN 37604							
James Wesley Denham, M.D.	(901) 210-5079	No*					
1747 Skyline Drive							
Unit 25							
Johnson City, TN 37604							
William Edward Kyle, D.O.	(423) 631-0272	Yes	No	\$400	No	Yes	Monthly
3114 Brownsmill Road							
Johnson City, TN 37604							
Jason John Della Vecchia, M.D.	(423) 232-5295	Yes	No	\$400	No	Yes	Monthly
Better Body Medicine							
600 North State Of Franklin Road							
Johnson City, TN 37604							
Chambless Rand Johnston III, M.D.	(423) 232-5295	Yes	No	\$400	No	Yes	Monthly
600 North State of Franklin Road							
Suite 5							
Johnson City, TN 37604							

Attachment B1 - Physicians Certified for Buprenorphine Treatment in proposed service area

First Name	Last Name	Suffix	Address Line 1	Address Line2	City	State	Zip Code	Phone
Charles	Fulton	M.D.	Charles A. Fulton MD	3763 Highway 11 West	Blountville	TN	37617	(423) 279-3860
Mack	Hicks	M.D.	3763 Highway 11W		Blountville	TN	37617	(423) 279-3860
Kevin	Catney	M.D.	Recovery Associates	1627 Highway 11 West	Bristol	TN	37620	(423) 274-0100
John	Barrowclough	M.D.	Appalachian Recovery Care, PLLC	2726 West State Street	Bristol	TN	37620	(423) 758-6744
Michael	Lady		Pathway Medical Group	113 Landmark Lane, Suite A	Bristol	TN	37620	(423) 573-7284
Shawn	Nelson	M.D.	3183 West State Street	Suite 1201	Bristol	TN	37620	(423) 764-0987
Matthew	Gangwer	M.D.	1895 Highway 126		Bristol	TN	37620	(423) 232-0222
Stephen	Wayne	M.D.	3183 West State Street	Suite 1201	Bristol	TN	37620	(423) 764-0987
Joseph	Radawi	M.D.	Appalachian Recovery Care, PLLC	2726 West State Street	Bristol	TN	37620	(423) 758-6744
Marianne	Filka	M.D.	Pathway Medical Group	113 Landmark Lane, Suite A	Bristol	TN	37620	(423) 573-7284
Gary	Neal	M.D.	260 Midway Medical Park	Suite 2G	Bristol	TN	37620	(423) 968-4444
John	Bandeian	M.D.	3169 West State Street		Bristol	TN	37620	(423) 968-3891
Charles	Wagner	M.D.	337 Bluff City Highway	Bradley Building Ste 101	Bristol	TN	37620	(423) 956-5028
Borzou	Azima	M.D.	1627 Highway 11 W		Bristol	TN	37620	(423) 274-0100
Linden	Fernando		2726 West State Street		Bristol	TN	37620	(423) 758-6744
Robert	Grindstaff	M.D.	Pathway Medical Group, Inc.	113 Landmark Lane Suite A	Bristol	TN	37620	(423) 573-7284
Douglas	Williams	M.D.	FirStep	3183 West State Street, Suite 1201	Bristol	TN	37620	(423) 764-2165
Earl	Wilson	M.D.	3183 West State Street	Suite 1201	Bristol	TN	37620	(423) 764-0987
Steven	Morgan	M.D.	3183 West State Street	Suite 1201	Bristol	TN	37620	(423) 764-0987
Pyung	Suh	M.D.	1729 Lynn Garden Drive		Kingsport	TN	37660	(423) 288-0223
Dana	Brown		208 Lynn Garden Drive		Kingsport	TN	37660	(423) 247-8811
Atif	Rasheed	M.D.	1076 Rotherwood Drive		Kingsport	TN	37660	(423) 963-4955
Jonathan	Wireman	M.D.	1901 Brookside Drive	Suite 101	Kingsport	TN	37660	(866) 755-4258
Bryan	Wood	M.D.	1901 Brookside Drive	Suite 101	Kingsport	TN	37660	(866) 755-4258
John	Tasker	M.D.	1303 East Center Street		Kingsport	TN	37660	(423) 384-2820
Arthur	Boyd	M.D.	1901 Brookside Drive	Suite 101	Kingsport	TN	37660	(866) 755-4258
Peter	Bockhorst	M.D.	201 Cassel Drive		Kingsport	TN	37660	(423) 245-9600
Michael	Martin	M.D.	1936 Brookside Drive	Suite C	Kingsport	TN	37660	(423) 384-4026
Sachdev	Somiah	M.D.	1944 Brookside Drive	Suite 1	Kingsport	TN	37660	(423) 245-2406
Daniel	Dickerson	M.D.	1901 Brookside Dr. Ste 101		Kingsport	TN	37660	(866) 755-4258
Randall	Falconer	M.D.	Recovery Assist LLC	1728 North Eastman Road	Kingsport	TN	37660	(423) 765-0089
Charles	Herrin	M.D.	2300 Pavilion Drive		Kingsport	TN	37660	(423) 857-5571
Jonathan	Lewis	M.D.	4600 Fort Henry Drive		Kingsport	TN	37663	(423) 224-3950
David	Merrifield	Jr., M.D.	Family Recovery Associates	1729 Lynn Garden Drive	Kingsport	TN	37665	(423) 288-0223
Bendik	Clark	M.D.	1729 Lynn Garden Drive		Kingsport	TN	37665	(423) 288-0223
Nicholas	Smith	M.D.	124 Gray Station Road	Suite 1	Gray	TN	37615	(423) 477-0600
Bruce	Boggs	M.D.	203 Gray Commons Circle		Gray	TN	37615	(423) 477-0600
Stephen	Cirelli	M.D.	Watauga Medical Care	501 East Watauga Avenue	Johnson City	TN	37601	(423) 722-8446
Stephen	Loyd	M.D.	205 High Point Drive		Johnson City	TN	37601	(423) 631-0732
Laura	Grobovsky	M.D.	501 East Watauga Avenue		Johnson City	TN	37601	(423) 722-8446
Christine	Carrejo	M.D.	Watauga Family Practice	501 East Watauga Avenue	Johnson City	TN	37601	(423) 722-8446
Cynthia	Partain	M.D.	401 East Main Street		Johnson City	TN	37601	(423) 929-2584
Matthew	Gangwer	M.D.	401 East Main Street	Suite 3	Johnson City	TN	37601	(706) 244-1390
David	Forester	M.D.	209 East Unaka Avenue		Johnson City	TN	37601	(423) 434-4677
Michael	Wysor	M.D.	Medical Care Walk In Clinic	105 Broyles Drive, Suite B	Johnson City	TN	37601	(423) 722-4000
Stephen	Cirelli	M.D.	Medical Care Clinic	105 Broyles Drive	Johnson City	TN	37601	(423) 722-4000
Edward	Crutchfield	M.D.	105 Broyles Street		Johnson City	TN	37601	(423) 946-3199
Jose	Lopez-Romero		100 West Unaka Avenue	Suite 4	Johnson City	TN	37601	(423) 928-1393
Aubrey	McElroy	Jr.	3201 Bristol Highway	Suite 4	Johnson City	TN	37601	(423) 262-8132
Wayne	Gilbert	M.D.	Watauga Family Practice	501 East Watauga Ave.	Johnson City	TN	37601	(423) 722-8446
Jack	Norden	M.D.	2406 Susannah Street		Johnson City	TN	37601	(423) 262-8633
Martin	Eason	M.D.	3114 Browns Mill Road		Johnson City	TN	37604	(423) 631-0432

Jason	Della Vecchia	M.D.	Better Body Medicine	600 North State Of Franklin Road	Johnson City	TN	37604	(423) 232-5295
Chambliss	Johnston	III, M.D.	600 North State of Franklin Road	Suite 5	Johnson City	TN	37604	(423) 232-5295
William	Kyle	D.O.	3114 Brownsmill Road		Johnson City	TN	37604	(423) 631-0272
Tracy	Goen	M.D.	3114 Browns Mill Road		Johnson City	TN	37604	(423) 631-0432
James	Denham	M.D.	1747 Skyline Drive	Unit 25	Johnson City	TN	37604	(901) 210-5079
Ray	Mettetal	Jr., M.D.	4113 Browns Mill Road		Johnson City	TN	37604	(423) 631-0432
LeRoy	Osborne	D.O.	Morgan Counseling & Associates	214 West Unaka Avenue	Johnson City	TN	37604	(423) 676-9015
Navneet	Gupta	M.D.	101 Med Tech Parkway	Suite 200	Johnson City	TN	37604	(423) 232-6120
Ralph	Reach		3114 Browns Mill Road		Johnson City	TN	37604	(423) 631-0432
William	Walker	M.D.	206 West Holston Avenue		Johnson City	TN	37604	(423) 612-1950
Michael	Tino	M.D.	Doctors Assisted Wellness	100 West Unaka Avenue, Suite #3,4,5	Johnson City	TN	37604	(423) 928-1393
Charles	Backus	III	Morgan Counseling Services	412 West Unaka Street	Johnson City	TN	37604	(423) 833-5547
John	Miller	M.D.	811 Wedgewood Road		Johnson City	TN	37604	(423) 282-5381
Hetal	Brahmbhatt	M.D.	500 Longview Drive		Johnson City	TN	37604	(423) 975-5444
Jack	Woodside	Jr., M.D.	917 West Walnut Street		Johnson City	TN	37604	(423) 439-6464
Robert	Reeves	M.D.	926 West Oakland Avenue	Suite 222	Johnson City	TN	37604	(423) 282-3379
Edgar	Ongtengco	M.D.	2514 Wesley Street	Suite 101	Johnson City	TN	37604	(423) 833-5547
Juan	Rodriguez	M.D.	Mental Health Clinic, Dept. of Psychiatr	P.O. Box 4000, La Mont Street	Mountain Home	TN	37684	(423) 926-1171x7703
David	Forester	M.D.	James H. Quillen VA Medical Center	P.O. Box 4000 116A	Mountain Home	TN	37684	(423) 926-1171x7150
Donald	Henson	Jr. M.D.	James H. Quillon VA Medical Center	Dept. of Psych., 116-A, P.O. Box 4000	Mountain Home	TN	37684	(423) 926-1171x2765
Tony	Yost	M.D.	184 Tamara Lane		Greeneville	TN	37743	(423) 422-2126
Elliott	Smith	Jr.	1406 Tusculum Boulevard	Suite 2003	Greeneville	TN	37745	(423) 636-0050
George	Kehler	II	65 Payne Road		Mosheim	TN	37818	(423) 422-2126
John	Shaw	M.D.	Recovery Associates of East Tennessee	65 Payne Road	Mosheim	TN	37818	(423) 422-2126
Robert	Locklear	M.D.	68 Railroad Street		Mosheim	TN	37818	(423) 450-0071
Kevin	Catney	M.D.	Recovery Associates	65 Payne Road	Mosheim	TN	37818	(423) 422-2126
Paul	Jett	M.D.	420 West Morris Boulevard	Suite 130	Morristown	TN	37813	(423) 586-9796
Dennis	Harris	M.D.	420 West Morris Boulevard	Suite 130	Morristown	TN	37813	(423) 587-9796
Devon	Smith	M.D.	1621 West Morris Boulevard	Suite A	Morristown	TN	37813	(423) 307-8088
Michael	Chavin	M.D.	1639 West Morris Boulevard		Morristown	TN	37814	(423) 586-0341
Daniel	Paul	M.D.	138 Industrial Drive South		Elizabethton	TN	37643	(423) 542-7007
Edgar	Perry	M.D.	401 Hudson Drive	Suite # 3	Elizabethton	TN	37643	(423) 543-2721
Scott	Caudle		1503 West Elk Avenue	Suite 1	Elizabethton	TN	37643	(423) 543-8619
Todd	Whitaker	M.D.	3614 Unicoi Drive		Unicoi	TN	37692	(423) 743-7151

Treatment Programs offering Buprenorphine Treatment

Indian Path Medical Center			2300 Pavilion Drive		Kingsport	TN	37660	(423) 857-7000
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ATTACHMENT B3 A

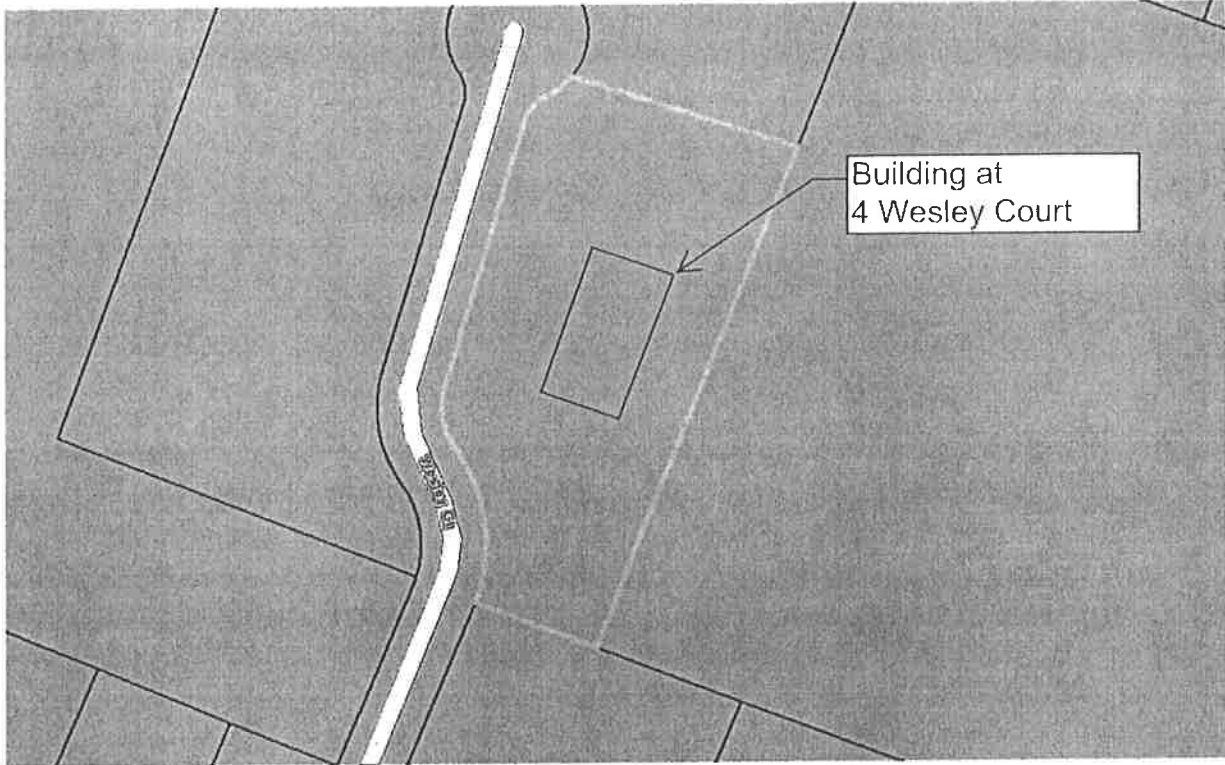
PLOT PLAN⁹¹

Washington County - Parcel: 038B B 006.00

SUPPLEMENTAL- # 1

March 25, 2013

12:15pm



Date Created: 3/18/2013

1. Parcel size: 1.66 acres
2. Building size: 8,208 square feet
3. All construction will be inside the four exterior walls of the building.
4. Names of streets, roads or highway that cross or border the site: Wesley Court

complete and ready for occupancy except for minor and incidental unpacking and assembly operations, location on jacks or other temporary or permanent foundations, connections to utilities, and the like. The following shall not be included in this definition:

- A. Travel trailers, pickup campers, motor homes, camping trailers, or other recreational vehicles.
- B. Manufactured modular housing which is designed to be set on a permanent foundation, and which meets the Standard Building Code Congress International.

MANUFACTURED HOME PARK: A parcel or tract of land under single ownership which has been planned and improved for the placement of manufactured homes for dwelling purposes; provided that all manufactured home parks existing at the time of passage of this Code not meeting the minimum requirements established in Article VI, Section 6.11, shall be considered a nonconforming use, and further provided that one manufactured home on a separate lot, shall not be considered a nonconforming manufactured home park.

MAP: The Flood Hazard Boundary Map (FHBM) or the Flood Insurance Rate Map (FIRM) for a community issued by the Agency.

MEAN SEA LEVEL: The average height of the sea for all stages of the tide. It is used as a reference for establishing various elevations within the floodplain. For purposes of the Floodplain Regulations, the term is synonymous with National Geodetic Vertical Datum (NGVD) or other datum, to which base flood elevations shown on the Flood Insurance Rate Map are referenced.

MEDICAL CLINIC: Medical services for out-patients only.

METHADONE TREATMENT CLINIC: A licensed facility for the counseling of patients and the distribution of methadone for outpatient, non-residential purposes only.

MOUNTING HEIGHT: The vertical distance between the surface to be lighted and the center of the apparent light source of a luminaire.

NATIONAL GEODETIC VERTICAL DATUM (NGVD): As corrected in 1929, is a vertical control used as a reference for establishing varying elevations within the floodplain.

6.13 - MS-1 MEDICAL SERVICES DISTRICT**6.13.1 INTENT:**

This district is intended to provide space for the harmonious development of medical facilities, services, and related support uses. The Medical Services District is intended to be protected from encroachment by land uses adverse to the location, operation, and expansion of medical use development.

6.13.2 PERMITTED USES:

Within the MS-1 Medical Services District the following uses are permitted:

- 6.13.2.1 Apothecaries, drug stores, and pharmacies;
- 6.13.2.2 Artificial limb and brace, therapeutic establishments, including the manufacturing, wholesale, and retail sales of products;
- 6.13.2.3 Banks;
- 6.13.2.4 Barber and beauty shops;
- 6.13.2.5 Bookstores including card and gift shops;
- 6.13.2.6 Churches, including parish houses;
- 6.13.2.7 Clinics;
- 6.13.2.8 Day-care centers and adult day-care centers;
- 6.13.2.9 Florist shops;
- 6.13.2.10 General office uses and office buildings, including professional and governmental;
- 6.13.2.11 Group homes, subject to the requirements of Subsection 6.8.2.3;
- 6.13.2.12 Hospitals for the treatment of human ailments, including psychiatric hospitals;
- 6.13.2.13 Laboratories - medical, dental, optical, pharmaceutical and related;
- 6.13.2.14 Medical, surgical, and dental supply businesses, both wholesale and retail;
- 6.13.2.15 Municipal, county, state or federal buildings or land uses;

- 6.13.2.16 Motels and hotels;
- 6.13.2.17 Nursing homes, rest homes, and convalescent homes;
- 6.13.2.18 Parking garages;
- 6.13.2.19 Public utility stations;
- 6.13.2.20 Residential homes for the aged, subject to the requirements of Subsection 6.6.1.5;
- 6.13.2.21 Restaurants, including drive-in services;
- 6.13.2.22 Retail sales and service establishments pertaining to any medically oriented product or service;
- 6.13.2.23 Schools;
- 6.13.2.24 Single-family residences;
- 6.13.2.25 Accessory structures and uses, provided they are located in the rear yard and set back a minimum of seven and one-half (7 ½) feet from all property lines;
- 6.13.2.26 Alternative tower structures; and
- 6.13.2.27 Heliports subject to compliance with the most recent edition of Federal Aviation Administration Circular 150/5390-2A.
- 6.13.2.28 Beer serving/sales establishments

6.13.3**USES PERMITTED BY APPROVAL AS SPECIAL EXCEPTION:**

The following uses are permitted when approved by the Board of Zoning Appeals as Special Exceptions as provided by Section 15.4:

- 6.13.3.1 Mortuary establishments, provided such establishments will not cause undue traffic congestion or create a traffic hazard;
- 6.13.3.2 Gasoline service stations, provided:
 - A. Service stations' principal and accessory buildings shall not be constructed closer than forty (40) feet to any side or rear lot line nor closer than forty-five (45) feet to any street right-of-way;

- B. Gasoline pump islands shall not be located closer than thirty (30) feet to any street right-of-way line nor closer than forty (40) feet to any side or rear lot line which abuts an RO-1 or more restrictive zone but which does not abut a street right-of-way; and
- C. Canopies shall not be constructed closer than thirty (30) feet from any street right-of-way. (Since the Code states that variances may only be given when special conditions prevent the beneficial use of land, if a gasoline station may be constructed on a lot, the land has resulted in beneficial use; and, therefore, no waiver may be given permitting the canopy to extend closer than thirty (30) feet to the street right-of-way.)

6.13.3.3 Tower Structures.

6.13.3.4 Methadone Treatment Clinic provided:

- A. The facility shall be fully licensed/certified by the appropriate regulating state agency;
- B. A certificate of need shall be obtained from the appropriate state agency prior to review by the Board of Zoning Appeals;
- C. The facility shall not be located within two hundred (200) feet of a school, day-care facility, or park as measured from property line to property line;
- D. The facility shall not be located within two hundred (200) feet of any establishment that sells either on-premise or off-premise alcoholic beverages as measured from property line to property line;
- E. The hours of operation shall be between 7:00 a.m. and 8:00 p.m.; and
- F. The facility shall be located on and primary access shall be from an arterial street.

6.13.3.5 Substance Abuse Treatment Facility provided:

- A. The facility shall be fully licensed/certified by the appropriate regulating state agency, if required;

Attachment B4 – Referral Services

Service	Provider	Location	Subcontract or Referral?
Psychiatry	Grace Pointe Counseling Center: Sullivan Rodney PhD	2 Redbush Ct, Johnson City, TN 37601	Referral
Comprehensive Medical Services	Johnson City Medical Center	400 N State of Franklin Rd, Johnson City, TN 37604	Referral
Vocational Placement	Tennessee Career Center	2515 Wesley Street Johnson City, TN 37601	Referral
Educational GED Assistance	Tennessee Career Center	2515 Wesley Street Johnson City, TN 37601	Referral
Family Planning	Agape Women's Services	817 W Walnut St Ste 5A, Johnson City, TN 37604	Referral
STD Testing	Express Testing	402 Princeton Rd Suite B Johnson City, TN 37601	Referral
Financial Counseling	Greater Eastern Credit Union	2110 W Mountcastle Dr, Johnson City, TN 37604	Referral

ATTACHMENT C, NEED, 1a

2008 Tennessee Department of Mental Health

NRMTF Central Registry Data

~~108A~~

110A

TDMHDD METHADONE REGISTRY
CONSUMERS BY COUNTY OF RESIDENCE AND CLINIC 02008

Patients served 01/01/2008 through 12/31/2008

4/27/2009

	Davidson Co. Middle Tennessee Treatment	Dyer Co. Midsouth Treatment Center	Hamilton Co. Volunteer Treatment Center, Inc.	Hardin Co. Solutions of Savannah	Knox Co. DRD Knoxville Medical Clinic	Knox Co. DRD Knoxville Medical Clinic - Central	Madison Co. Jackson Professional Associates	Shelby Co. ADC Recovery and Counseling	Shelby Co. Memphis Center for Research and	Shelby Co. Raleigh Professional Associates
Anderson			72		74	81	2		1	
Bedford	4	1	5				1			
Benton	1			1			31			
Bledsoe			6							
Blount			88		62	68				
Bradley	1		95			1	1			
Campbell			66		77	78				
Cannon	1									
Carroll	1			1			24			
Carter			4		2	1				
Cheatham	75								2	
Chester				4			42		2	
Claiborne			20		31	43				
Clay	3		2			2				
Cocke			1		10	12				
Coffee	13		13				1			
Crockett		2					9		1	

108B
110B

Beginning April 2008 the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) began collecting data regarding non-residential opioid treatment facilities (Facilities) in the State of Tennessee. This data is derived from information submitted by each Facility. TDMHDD can neither guarantee nor attest to the accuracy of any data submitted by or on behalf of the Facilities.

TDMHDD METHADONE REGISTRY
CONSUMERS BY COUNTY OF RESIDENCE AND CLINIC

Patients served 01/01/2008 through 12/31/2008

4/27/2009

	Davidson Co. Middle Tennessee Treatment	Dyer Co. Midsouth Treatment Center	Hamilton Co. Volunteer Treatment Center, Inc.	Hardin Co. Solutions of Savannah	Knox Co. DRD Knoxville Medical Clinic	Knox Co. DRD Knoxville Medical Clinic - Central	Madison Co. Jackson Professional Associates	Shelby Co. ADC Recovery and Counseling	Shelby Co. Memphis Center for Research and	Shelby Co. Raleigh Professional Associates
Cumberland	1		12			1				
Davidson	694		9			1	6			
Decatur	1			5			6			
DeKalb	19									
Dickson	31		1				2			
Dyer		87					62	3	3	1
Fayette	1	1	1				2	8	6	6
Fentress	6		6							
Franklin	1		2		2					
Gibson		2		1			25			
Giles	1									
Granger			24		24	47				
Greene					2	8				
Grundy			2							
Hamblen			14		38	31				
Hamilton	6		382		1	4				
Hancock					17	2				
Hardeman			1	1			19	2	3	

Beginning April 2008 the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) began collecting data regarding non-residential opioid treatment facilities (Facilities) in the State of Tennessee. This data is derived from information submitted by each Facility. TDMHDD can neither guarantee nor attest to the accuracy of any data submitted by or on behalf of the Facilities.

TDMHDD METHADONE REGISTRY
CONSUMERS BY COUNTY OF RESIDENCE AND CLINIC

Patients served 01/01/2008 through 12/31/2008

4/27/2009

	Davidson Co. Middle Tennessee Treatment	Dyer Co. Midsouth Treatment Center	Hamilton Co. Volunteer Treatment Center, Inc.	Hardin Co. Solutions of Savannah	Knox Co. DRD Knoxville Medical Clinic	Knox Co. DRD Knoxville Medical Clinic - Central	Madison Co. Jackson Professional Associates	Shelby Co. ADC Recovery and Counseling	Shelby Co. Memphis Center for Research and	Shelby Co. Raleigh Professional Associates
Hardin				254			29	1		2
Hawkins	1		2		5	15				
Haywood							3		1	2
Henderson				5			16			
Henry	2						42			
Hickman	51			1			4		2	
Houston	1						1			
Humphreys	11						6	1		
Jackson	10		1							
Jefferson			34		47	39		1	1	
Johnson	1				1					
Knox	6		246		433	383	1		2	
Lake	1	45					55		1	
Lauderdale		3					6			4
Lawrence	3			1						
Lewis	15			1						
Lincoln	1									
Loudon	1		86		15	21				

Beginning April 2008 the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) began collecting data regarding non-residential opioid treatment facilities (Facilities) in the State of Tennessee. This data is derived from information submitted by each Facility. TDMHDD can neither guarantee nor attest to the accuracy of any data submitted by or on behalf of the Facilities.

	Davidson Co. Middle Tennessee Treatment	Dyer Co. Midsouth Treatment Center	Hamilton Co. Volunteer Treatment Center, Inc.	Hardin Co. Solutions of Savannah	Knox Co. DRD Knoxville Medical Clinic	Knox Co. DRD Knoxville Medical Clinic - Central	Madison Co. Jackson Professional Associates	Shelby Co. ADC Recovery and Counseling	Shelby Co. Memphis Center for Research and	Shelby Co. Raleigh Professional Associates
Macon	7		1							
Madison	1	3		3	1		184	1	2	2
Marion			24							
Marshall	11		1					1		
Maury	42		1			1				
McMinn			69		3					
McNairy	1			116			57	1		
Meigs			22			1				
Monroe			32		2	2				
Montgomery	22		1			1				
Morgan			21		10	11				
Obion	1	62					71			2
OUT OF ST.	164	9	236	125	28	29	44	175	287	66
Overton	18		24				1			
Perry			1	2			1			
Pickell	1		7							
Polk			11			1				
Putnam	23		24							

Beginning April 2008 the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) began collecting data regarding non-residential opioid treatment facilities (Facilities) in the State of Tennessee. This data is derived from information submitted by each Facility. TDMHDD can neither guarantee nor attest to the accuracy of any data submitted by or on behalf of the Facilities.

TDMHDD METHADONE REGISTRY
CONSUMERS BY COUNTY OF RESIDENCE AND CLINIC

Patients served 01/01/2008 through 12/31/2008

4/27/2009

	Davidson Co. Middle Tennessee Treatment	Dyer Co. MidSouth Treatment Center	Hamilton Co. Volunteer Treatment Center, Inc.	Hardin Co. Solutions of Savannah	Knox Co. DRD Knoxville Medical Clinic	Knox Co. DRD Knoxville Medical Clinic - Central	Madison Co. Jackson Professional Associates	Shelby Co. ADC Recovery and Counseling	Shelby Co. Memphis Center for Research and	Shelby Co. Raleigh Professional Associates
Rhea			25							
Roane	2		121		20	10	2			
Robertson	23	1					1			
Rutherford	145			1		1	3			
Scott			7		3	7				
Sequatchie			8							
Sevier	2		50		101	83				
Shelby	4	2		2		1	6	202	388	220
Smith	28							1		
Stewart	2									
Sullivan			1		10	8				
Sumner	96		1							
Tipton		1		1			2	5	22	18
Trousdale	2									
Unicoi			1			1			1	
Union			15		27	22				
UNKNOWN	18	2	35	9	13	13	11	6	16	2
Van Buren			4							

Beginning April 2008 the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) began collecting data regarding non-residential opioid treatment facilities (Facilities) in the State of Tennessee. This data is derived from information submitted by each Facility. TDMHDD can neither guarantee nor attest to the accuracy of any data submitted by or on behalf of the Facilities.

TDMHDD METHADONE REGISTRY
CONSUMERS BY COUNTY OF RESIDENCE AND CLINIC

Patients served 01/01/2008 through 12/31/2008

4/27/2009

	Davidson Co. Middle Tennessee Treatment	Dyer Co. Midsouth Treatment Center	Hamilton Co. Volunteer Treatment Center, Inc.	Hardin Co. Solutions of Savannah	Knox Co. DRD Knoxville Medical Clinic	Knox Co. DRD Knoxville Medical Clinic - Central	Madison Co. Jackson Professional Associates	Shelby Co. ADC Recovery and Counseling	Shelby Co. Memphis Center for Research and	Shelby Co. Raleigh Professional Associates
Warren	4		11							
Washington					4	2				
Wayne	1			11						
Weakley		1				1	14			
White	5		13							
Williamson	100	2					2			
Wilson	102		1			2				1
Total	1,789	224	1,963	545	1,063	1,035	795	408	741	326

Beginning April 2008 the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) began collecting data regarding non-residential opioid treatment facilities (Facilities) in the State of Tennessee. This data is derived from information submitted by each Facility. TDMHDD can neither guarantee nor attest to the accuracy of any data submitted by or on behalf of the Facilities.



145 Enterprise Drive, Unit A
Cumming, GA 30040
678-300-6227

104
Attachment C, Economic Feasibility
(Construction Cost Estimate)

SUPPLEMENTAL- # 1

March 25, 2013

12:15pm

Budgetary Project Estimate for Tri-Cities Holdings, LLC
5 Wesley Court
Johnson City, TN

February 28, 2013

To:
Tri-City Holdings, LLC
c./o Steve Kester
6555 Sugarloaf Parkway
Duluth, GA 30097

Per your request, we have developed a budgetary estimate to renovate the property at 4 Wesley Court, Johnson City, TN.

The work to be done includes:

- Demolition of unused walls
- Build-out offices from existing walls
- Reconfigure HVAC
- Plumbing to exam room
- Add electrical and low voltage to offices
- Build 4 dosing windows
- Build payment window/check-in station
- Add 2 new offices
- Painting
- Travel and project management

All of our work will be permitted and done in conformance with local, State and Federal construction codes, standards and requirements, including the Americans With Disabilities Act. Specifically, we are aware of, and will conform to the latest American Institute of Architects Guidelines for Design and Construction of Hospitals and Health Care Facilities.



CHAS PROJECTS, LLC
145 Enterprise Drive, Unit A
Cumming, GA 30040
678-300-6227

105

SUPPLEMENTAL- # 1

March 25, 2013

12:15pm

Total square footage affected: 8,000

Cost basis: \$15-\$20/square foot

Estimate: \$120,000 - \$160,000

This is NOT a firm quote. It is an budgetary estimate based upon similar work at comparable clinics.

Please call to schedule a detailed walk-through and firm quote.

Signed,

Robert Burke
President

Attachment C.

Economic Feasibility.10.

March 28, 2013

9:00 am

Facsimile



Maxim Group LLC
99 Sunnyside Blvd Ext.
Woodbury, NY 11797
Telephone (516) 393-8300
Facsimile (516) 364-1310
Website www.maximgrp.com

To

Steve Kesker

Company

Fax No

404-537-3780

From

Michael Fenton

Date

March 27, 2013No of Pages
(including cover)2

Re

Account Balance

Message:

Please see attached.Your Balances as of March 27, 2013

Name of IP: MICHAEL FENTON - (KESTER LP) - NYSE: KESTER - Balances - Customer view (Delayed)

Key Values

	As of 03/27/2013
Long Market Value ¹ :	
Short Market Value:	\$788,250.41
Securities Owed ² :	\$0.00
Cash Mgmt Balance:	\$0.00
Cash:	\$0.00
Net Worth:	\$762,888.60
Total Annuity Value ³ :	\$1,551,139.01
Total Account Value:	\$0.00
Debit Interest Rate:	\$1,551,139.01
	\$0.00

Funds Available/Due

	As of 03/17/2013
Funds Available for Withdrawal:	
Funds Available to Trade:	\$762,888.60
Day Trade Buying Power(as of Previous Day):	\$762,888.60
Funds Due(as of Previous Day) ⁴ :	\$0.00
	\$0.00

¹Long Market Value does not include options, commercial paper, annuities, precious metals, alternative investments and foreign currencies.

²'Securities Owed' is as of Previous Day.

³Annuity values are as of Previous Day and may fluctuate between 4:00AM (ET) and 6:00AM (ET) while data sources make updates.

⁴'Funds Due' is calculated as of the Previous Day. The Funds Due amount does not consider amounts due for purchases, sales or other transactions executed today.

Values computed based on quote data delayed per exchange agreement. NYSE and AMEX data delayed at least 15 minutes for NYSE, AMEX, NASDAQ, OTC, OTCBB and OPRA.

This report is a service from your Investment Professional, not a substitute for your account statements and confirmations. This report is prepared as of trade date rather than settlement date and may be prepared on a different date than your statement. This report uses information from sources that Pershing believes to be reliable, but Pershing cannot guarantee the accuracy of this information or the reliability of these sources. If you find discrepancies in this report, please contact your Investment Professional.
Prepared By (PNXMMFEN) at 03/27/2013 11:34

©NetX360, All Rights Reserved.

Steve,

Please see above, your account balance
at Maxim as of March 27, 2013

- Mike Fenton
Mike FENTON, SUP
Maxim Group
212-895-3698

Proposed Service Area

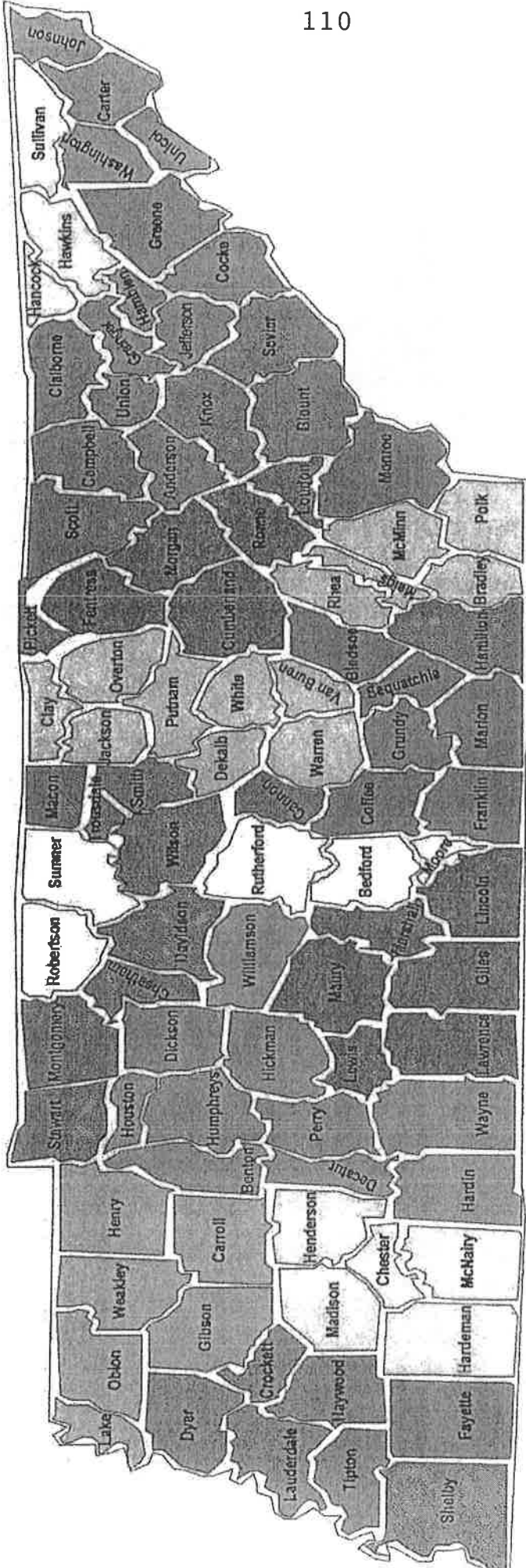


Proposed Service Area includes the counties that are those boxed above, including Sullivan, Washington, Greene, Hamblen, Carter, Hawkins, Cocke, Unicoi and Johnson. Washington, Carter, Johnson and Unicoi counties form Methadone Service Area #1, Sullivan and Hawkins county are in MSA #2, and Green, Cocke and Hamblen counties are in MSA #3.

Attachment C 3.

Tennessee Methadone Service Areas

January 2002



Possible Methadone Service Areas for NR Methadone Clinic Locations

MSA #	County	Popn	RSA #	County	Popn
1	Washington	107,200	13	Hickman	22300
	Johnson	17500		Perry	7600
	Carter	56700		Wayne	16800
	Unicoi	17700		Dickson	43200
	S/T	199,100		Humphreys	17900
2	Sullivan	153,000		Houston	8100
	Hawkins	53500		Hardin	25600
	Hancock	6800		Decatur	11700
	S/T	213,300		Benton	16500
				S/T	169700
3	Greene	62900	14	Montgomery	134800
	Cocke	33600		Stewart	12400
	Hamblen	58100		Cheatham	35900
	Jefferson	44300		S/T	183100
	Grainger	20700			
	S/T	219600	15	Williamson	126600
4	Claiborne	29900	16	Sumner	130400
	Union	17800		Robertson	54400
	Campbell	39900		S/T	184800
	Scott	21100			
	Anderson	71300	17	Madison	91800
	S/T	180000		McNairy	24700
5	Sevier	71200		Chester	15600
	Blount	105800		Henderson	25500
	Monroe	39000		Hardeman	28100
	S/T	216000		S/T	185700
6	Cumberland	46800	18	Weakley	34900
	Morgan	19800		Henry	31100
	Roane	51900		Carroll	29500
	Loudon	39100		Gibson	48200
	Fentress	16600		Obion	32500
	Pickett	4900		Lake	8000
	S/T	179100		S/T	184200
7	Putnam	62300	19	Dyer	37300
	Overton	20100		Lauderdale	27100
	Jackson	11000		Tipton	51300
	Warren	38300		Haywood	19800
	Clay	8000		Crockett	14500
				Fayette	28800

120

121

**LETTERS OF SUPPORT
(TO DATE)**

March 25, 2013

12:15pm

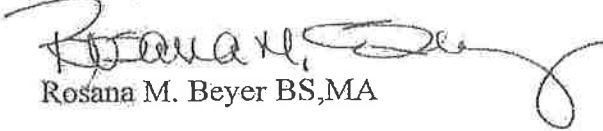
March 17, 2013
8564 Horton Hwy.
Greeneville, TN 37745

2013 MAR 21 AM 9:13

TO WHOM IT MAY CONCERN: I have worked with young people for over thirty years dealing with their educational, emotional, and physical everyday problems. For the majority of the young people I worked with, had used drugs or was using them on a daily basis to rid themselves of their physical and emotional pain.

Therefore, I firmly believe in a methadone clinic in the Johnson City area. We, the community, and the young people, would truly benefit from it conception.

Thank-you so much,

A handwritten signature in dark ink, appearing to read "Rosana M. Beyer", with a long, sweeping horizontal stroke extending to the right.

Rosana M. Beyer BS,MA

To Whom This May Concern,

2013 MAR 20 AM 9:07

My name is Kathy Ostertag, RN and I am writing in support of the Certificate of Need for an opiate treatment program (OTP) in Johnson City. I have no financial interest in the company trying to open the OTP.

I have worked at three OTPs in the Asheville, North Carolina area. In all three clinics, many of the patients come from the Tri Cities area and drive great distances, crossing the state line to get treatment. I believe that for every patient that made the trek, 2 or 3 did not. Distance and time are the leading barriers to getting treatment. You should worry about these people who don't get treatment. Statistically, 80% of addicts support their addiction through crime - theft, prostitution, forgery, etc.

Let me give you an example of a typical day in the life of a person/family in recovery who has made the brave choice to get help for their addiction: A young family living in the Johnson City area - one maybe both parents have struggled for years with addiction - but now they have hope - they have a place where they can get relief from the physical pain of addiction and the support of a staff of Nurses, Doctors, and highly qualified counselors to help them in this brave effort. Finally without the chain of addiction and the lifestyle that goes along with it - the father and mother now both have legitimate jobs are able to provide their families with a good and safe home - gained back the respect they had long ago lost for themselves. The one draw back is it is over an hour away on often dangerous roads in inclement weather. - So their day starts out with an alarm that rings at about 1:00 AM - they get up, get their kids up from a good nights sleep, place their sleeping children in the car for the long drive to Asheville - an hour or more away - arriving at about 3:00 AM at the treatment program to wait for the clinic to open at 5:00 AM - they arrive so early to ensure a place at the front of the line, as there are so many others their that have made the same long trip from your area that day - to facilitate getting back home earlier. They enter the clinic, they usually see their counselor, get their medication and usually several times a month have a urine drug screen - all of this taking at least an hour. Now they drive back home arriving there around 7:00 AM - and now there day begins - just like yours and mine. They get ready for work - get the kids' fed and ready for school and/or day care - leave the house to have a productive day just like the rest of us. Except this family has already had a full day. Now multiply this by 1000 people/families in treatment - This facility is NEEDED.

March 25, 2013

12:15pm

Ask yourselves is it fair that the residents of the Johnson City area should have to endure such hardship in order to gain their lives back. These are members of our community that you and I work with everyday - side by side - families just like yours and mine - wanting a better life for themselves and there children - should it be so hard for them - ask yourself that. I can't tell you how many times I have heard the words "Kathy - This place has saved my life". As a health care professional I can tell you there is nothing better, or more rewarding to know that you have helped to improve the lives of others - this program will change lives in your community.

For those who do make the drive, many, like the family I describe above, are under great stress struggling with the finances and time to make the commute. Many drop out of treatment because they can't afford the gas, or have work or family commitments that conflict. Dropping out of treatment often means relapsing back to drugs.

Companies want to open in the Tri Cities area because there is a desperate need. I understand locals are concerned about crime and property values. I can tell you first hand after 12 years working in addiction treatment - these facilities are good neighbors - going un noticed in their locations - supporting out reach programs in the community with education and support of community programs - these substance abuse treatment programs SAVE lives and FAMILIES and in turn help SAVE our communities. Many studies have shown that the far greater risk is the LACK of treatment.

Approve the CON. Lower crime. Lower drug use. Less disease. Compassionate care.

Sincerely,


Kathy Osterlag, RN

To whom it may concern,

Concerning the proposed methadone clinic in Johnson City.

I am in full support of it. Abstinence works in some people but not in others.

If you know you're going to get your daily dose you are more likely to be able to hold a job and live your life.

Prescription drug abuse is rampant in the area. Chasing that dose everyday is no fun.

Addiction knows no social or economic boundaries. It ranges from soccer moms to street junkies. No one wants to be a junkie and a clinic would provide them with a pathway to get clean without constantly trying to find drugs and come up with the money to buy them. That is where most of the crime comes in.

As far as crime around the clinic, that's what the police are for.

Please issue a certificate of need. The problems are just getting worse.

Thank you

Ross Jackson

Ross Jackson

PO Box 185

Chuckey, TN 37641

March 25, 2013

12:15pm

Joy Jackson

PO Box 185

Chuckey, TN 37641

March 18, 2013

2013 MAR 21 AM 9:14

Health Services and Development

Agency

The Frost Bldg. Third Floor

161 Rosa L. Parks Blvd.

Nashville, TN 37243

To Whom It May Concern:

As a citizen of Upper East Tennessee, I am writing in support of approval of a certificate of need for a methadone clinic in Johnson City.

Prescription drug and opiate addiction has become rampant in our area and is reflected in increased criminal activity, unemployment and the breakup of families.

No addict started out with the thought that he/she could become physically dependent on these drugs. No one wants to be a junkie. Many want to quit but do not know where to turn. A treatment clinic in our area could help many hundreds of addicts turn their lives around and once again be productive members of our society. They would be able to work and lead a normal life close to home. As it is now, addicts from the Tri-cities area must drive to Knoxville or Asheville, NC every day for treatment, which is nearly impossible while trying to hold down a job. Many will give up because of this limitation.

A methadone clinic in Johnson City would be a positive thing for this community and all of its citizens.

Thank you,



Joy Jackson

Tennessee Health Services And Development Agency
Melanie M. Hill, Executive Director
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

2013 MAR 21 AM 9:14

March 11, 2013

Ms. Hill:

I am writing you in support of Tri-Cities Holding's Certificate of Need for an opiate treatment program in Johnson City, Tennessee.

I have the unique advantage of treating over 1,000 opiate-addicted patients both in an opiate treatment program and a private physician's office. I have medically supervised methadone, buprenorphine and abstinence-based services to treat those suffering from opiate addiction. I have no financial interest in Tri-Cities Holdings, nor am I a part of the staff or management.

There are several points I wish your Agency to know about treating those suffering from opiate addiction.

1. Physician-based practices that offer buprenorphine treatment are significantly disadvantaged relative to opiate treatment programs:
 - a. These offices rarely provide counseling services, which are a critical component to treatment and a patient's ultimate path to independence
 - b. Private doctor's office don't have the same requirements for drug testing, attendance and group therapy that are critical to ensure compliance and a patient's commitment
 - c. The hours of operation of a doctor's office do not meet a patient's need to balance work and family commitments
 - d. Addicts are co-mingled with the other patients in the office which creates shame and discomfort
 - e. Staff at opiate treatment programs (nurses, counselors, doctors, etc.) are specifically trained and credentialed to treat the specific needs of those suffering from opiate addiction
 - f. When compared to the cost and services of an opiate treatment program, doctors' offices are significantly over-priced
2. Johnson City is trading the perceived problems of a methadone clinic with the very real costs of opiate addiction. Distance plays a significant role in treatment. In my Atlanta-based practices, I frequently see patients who travel great distances because the community they live in does not want a clinic or is too small to support a clinic. As you know, patients who are just entering treatment must come every day. This is the precise time that they are most vulnerable to relapse, and this distance places a tremendous burden on them.

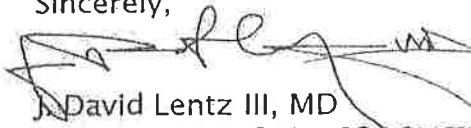
Further, for every patient that travels far for treatment, he or she will tell you they know 2 or 3 addicts that want treatment, but cannot make the commitment of time or money associated with a long daily commute.

Untreated addicts commit crime to support their habit, leave their families, get incarcerated, and clog emergency rooms. In keeping a clinic out, Johnson City is inviting in many more problems. March 25, 2013 12:15pm

3. Whatever the perceived problems of opiate treatment programs, Johnson City has exported them to the nearest communities that will support treatment. Does this seem like the right thing to do?
4. The perceived problems of opiate treatment programs are just that, perceived. There are nearly 1,300 of these clinics in the US. If they were as bad as the Johnson City officials have made them out to be, do you think they would be tolerated? The fact is, these clinics open and operate with a whimper, not a bang. The worst problems are parking and smoking, which pale in comparison to theft, prostitution, HIV, and broken families.
5. Most of the opposition that I have read is from uninformed people who perpetuate myths. Have you heard from former patients, staff or neighboring businesses? Asheville has five of these clinics, yet it's a wonderful city.
6. Speaking of myths, here are some doozies: "Methadone is just trading one drug for another. Addicts should just go cold turkey." Less than 10% of opiate addicts can withdraw "cold turkey" without relapse. Many pain pills are just as addictive as heroin and substantial research has shown that abstinence-based withdraw is far less successful than medication-based treatment.
7. Johnson City's problems may get worse. "Pain mills" and other diversion operations are being successfully identified and shut down. That's the good news. However, if pain pills addicts have no treatment, they will likely turn to heroin, which has become cheaper and easier to obtain in most communities.

I encourage you to take an objective review of the facts. Doing so will lead you to the decision that this project is best for the community.

Sincerely,



J. David Lentz III, MD
GEORGIA MEDICAL ASSOCIATES PC
2121 Fountain Drive
Suite A
Snellville, GA 30078

NOTIFICATION REQUIREMENT

March 25, 2013**12:15pm**

Tri-Cities Holdings LLC
d/b/a Trex Treatment Center
6555 Sugarloaf Parkway Suite 307-137
Duluth, GA 30097

Phone: 404-664-2616

E-mail:
swkester@gmail.com

March 5, 2013

VIA CERTIFIED MAIL/RETURN RECEIPT REQUESTED

Rep. James (Micah) Van Huss
R-Jonesborough District 6
301 6th Avenue North
Suite 23 Legislative Plaza
Nashville, Tennessee 37243

Mayor Dan Eldridge
Washington County Mayor's Office
103 W. Main St.
Jonesborough, Tennessee 37659

Senator Rusty Crowe
R-Johnson City District 3
301 6th Avenue North
Suite 8 Legislative Plaza
Nashville, Tennessee 37243

Mayor Jeff Banyas
Municipal & Safety Building
601 E. Main Street
Johnson City, Tennessee 37601

Gentlemen:

In accordance with Tenn. Code Ann. Section 68-11-1607, please be advised that an application for a nonresidential methadone treatment facility to be located at 4 Wesley Court, Johnson City, TN 37601 has been filed with the Tennessee Health Services and Development Agency by Tri-Cities Holdings LLC d/b/a Trex Treatment Center.

Sincerely,
Tri-Cities Holdings LLC

Steve Kester, Manager.

SWK/jd

CERTIFIED MAIL™ RECEIPT (Domestic Mail Only; No Insurance Coverage Provided)			
For delivery information visit our website at www.usps.com			
71791000164916897354 NASHVILLE TN 37243			
Postage	\$ 0.46	\$0.46	
Certified Fee	\$3.10	\$3.10	
Return Receipt Fee (Endorsement Required)	\$2.55	\$2.55	
Restricted Delivery Fee (Endorsement Required)	\$0.00	\$0.00	
Total Postage & Fees	\$ 6.11	\$6.11	
Sent To Street, Apt. No.; or PO Box No. City, State, Zip+4		Rep. James (Micah) Van Huss 301 6th Avenue North Suite 23 Legislative Plaza Nashville, TN 37243	
PS Form 3800, August 2006 See Reverse for Instructions			

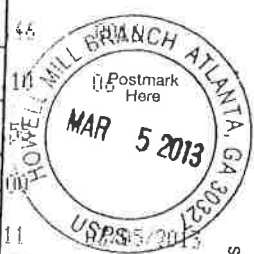
Code: TCHVan Huss

SUPPLEMENTAL- # 1

March 25, 2013

12:15pm

CERTIFIED MAIL™ RECEIPT (Domestic Mail Only; No Insurance Coverage Provided)			
For delivery information visit our website at www.usps.com			
71291000164916897538 JOHNSON CITY TN 37601			
Postage	\$ 0.46	40	46
Certified Fee	\$3.10	30	10
Return Receipt Fee (Endorsement Required)	\$2.55	25	55
Restricted Delivery Fee (Endorsement Required)	\$0.00	00	00
Total Postage & Fees	\$ 6.11	60	11
Sent To Mayor Jeff Banyas Municipal & Safety Building 601 E. Main Street Johnson City, TN 37601 Street, Apt. No., or PO Box No. City, State, Zip+4			
PS Form 3800, August 2006 See Reverse for Instructions			



Code: TCH/Banyas

SUPPLEMENTAL- # 1
March 25, 2013
12:15pm

CERTIFIED MAIL™ RECEIPT (Domestic Mail Only; No Insurance Coverage Provided) For delivery information visit our website at www.usps.com		
JONESBOROUGH, TN 37659		
7171000164716077567		
Postage	\$0.46	
Certified Fee	\$3.10	
Return Receipt Fee (Endorsement Required)	\$2.35	
Restricted Delivery Fee (Endorsement Required)	\$0.00	
Total Postage & Fees	\$6.11	
Sent To Mayor Dan Eldridge Washington County Mayor's Office Street, Apt. No.; 103 W. Main Street or PO Box No. Jonesborough, TN 37659 City, State, Zip+4		
PS Form 3800, August 2006 See Reverse for Instructions		



Code: TCH/Eldridge

SUPPLEMENTAL- # 1
 March 25, 2013
 12:15pm

CERTIFIED MAIL™ RECEIPT
 (Domestic Mail Only; No Insurance Coverage Provided)
 For delivery information visit our website at www.usps.com

71781000344816897422
 NASHVILLE TN 37243

Postage	\$ \$0.46	\$0.46
Certified Fee	\$3.10	\$3.10
Return Receipt Fee (Endorsement Required)	\$2.55	\$2.55
Restricted Delivery Fee (Endorsement Required)	\$0.00	\$0.00
Total Postage & Fees	\$ \$6.11	\$6.11

Sent To: Senator Rusty Crowe
 301 6th Avenue North
 Suite 8 Legislative Plaza
 Nashville, TN 37243

Street, Apt. No.,
 or PO Box No.
 City, State, Zip+4

PS Form 3800, August 2006 See Reverse for Instructions



Code: TCH/Crowe

SUPPLEMENTAL- # 1
March 25, 2013
12:15pm

Certified Number	Sender	Recipient	Date Mailed	Delivery Status
71791000164916897354		Rep. James (Micah) Van Huss, 301 6th Avenue North, Suite 23 Legislative Plaza, Nashville, TN, 37243 Code: TCH/Van Huss	2/28/2013	Delivered March 07, 2013 GREEN CARD SIGNED
71791000164916897422		Senator Rusty Crowe, 301 6th Avenue North, Suite 8 Legislative Plaza, Nashville, TN, 37243 Code: TCH/Crowe	2/28/2013	Delivered March 07, 2013 GREEN CARD SIGNED
71791000164916897538		Mayor Jeff Banyas, Municipal & Safety Building, 601 E. Main Street, Johnson City, TN, 37601 Code: TCH/Banyas	2/28/2013	Delivered March 08, 2013 GREEN CARD SIGNED
71791000164916897569		Mayor Dan Eldridge, Washington County Mayor's Office, 103 W. Main Street, Jonesborough, TN, 37659 Code: TCH/Eldridge	2/28/2013	Delivered March 08, 2013 GREEN CARD SIGNED

ARTICLES

AFFIDAVIT

2013 MAR 25 PM 12 10

STATE OF GEORGIA
COUNTY OF FULTON

NAME OF FACILITY: TRI-CITIES HOLDINGS LLC
4 WESLEY COURT
JOHNSON CITY, TENNESSEE

I, STEVE KESTER, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Steve W. Kester / MANAGER
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 25 day of March, 2013
witness my hand at office in the County of Fulton, State of Georgia.

Theresa P. L. L. L.
NOTARY PUBLIC

My commission expires 03/27/14.

COPY-
SUPPLEMENTAL-2

Tri-Cities Holdings, LLC

CN1303-005

Law Offices
James A. Dunlap Jr. & Associates LLC
801 West Conway Drive NW
Atlanta, Georgia 30327

SUPPLEMENTAL- # 2

March 28, 2013

9:00 am

2013 MAR 28 AM 9:02

Phone: (404) 354-2363

Fax: (404) 745-0195

E-mail:

jim@jamesdunlaplaw.com

March 27, 2013

VIA FEDERAL EXPRESS

Phillip Earhart
Tennessee Health Services And Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

Re: **Application for Certificate of Need**
Applicant: Tri-Cities Holdings LLC

Dear Phillip:

Please find enclosed an original and two copies supplement information for the Application for Certificate of Need by Tri-Cities Holdings LLC.

Please contact me if you have any questions or if I may be of assistance.

Sincerely,
James A. Dunlap Jr. & Associates LLC



James A. Dunlap Jr.

JAD/jd
Enclosures

132
Tri Cities Holdings, LLC
6555 Sugarloaf Parkway
Suite 307-137
Duluth, GA 30097
404-664-2616

SUPPLEMENTAL- # 2

March 28, 2013

9:00 am

2013 MAR 28 AM 9:02

March 27, 2013

Phillip Earhart
Health Services Development Examiner
Health Services & Development Agency
161 Rosa Parks Boulevard
Nashville, TN 37203

RE: Certificate of Need Application CN1303-005
Tri-Cities Holdings, LLC

Dear Mr. Earhart:

Thank you for reviewing our revised application and we are pleased to respond to your remaining questions.

We have listed your questions in **bold** and typed our response immediately following. We have also included the following attachments:

- Revised Page 22
- Project Costs Chart (should go after page 29, and be page numbered 29A)
- Revised Financial Resources documentation, should replace pages 113 and 114 and again on pages 116 and 117
- Projected Data Chart (confirms pages 30, 31 and 32; page 36 should be deleted)
- Executed Affidavit

1. Section A, Applicant Profile, Item 6

TennCare covers the drug buprenorphine for treatment of opiate addiction. The medication, medical services and transportation to providers are a covered TennCare benefit. With this in mind, please clarify the reason why you are not planning to accept TennCare for suboxone patients. What incentive does a TennCare patient have to come to the proposed clinic to receive buprenorphine when their medications and transportation services may be paid by TennCare by going to a private provider who prescribes suboxone who is already located in the proposed service area?

Response: None of the 12 opiate treatment programs in Tennessee currently accept TennCare based on a 3/25/2013 telephone survey. The Applicant is not planning on accepting TennCare for the following reasons:

- The investment in personnel and systems, the on-going compliance and audit requirements, and the risk of penalties for non-compliance do not warrant the added revenue
- Based on the Applicant's experience, there are additional risks associated with comingling TennCare patients with self-pay patients (arguments, humiliation, etc.) such that is not worth implementing TennCare

Pertaining to the reasons a patient would chose our facility over a private provider, the Applicant states:

- Most private providers are general family practices and do not have the expertise or focus our program would offer.
- Most private providers do not offer early morning hours that accommodate work, school and family obligations.
- Most private providers do not offer counseling or group meetings in their office, which our program would offer.
- Most private providers do not drug test, implement drug diversion control, test for HIV, TB, etc., which our program would offer.

However, if a private provider provided the services, hours and operation, and expertise listed above, and accepted TennCare, a TennCare patient seeking buprenorphine treatment would have no reason to use our facility.

2. Section A, Applicant Profile, Item 12.

Please clarify if methadone treatment is offered as part of the TennCare benefit package for patients ages 18-20 years of age. The response in the first supplemental response was unclear.

Response: Applicant sources the following quotation from TennCare Quick Guide May 2012, p. 9 and 12.

“Methadone Clinic Services – Not Covered, except for children under age 21.
[Rules 1200-13-13-.04, 1200-13-14-.10, 1200-13-14-.04, & 1200-13-14-.10].”

Source: TennCare Quick Guide May 2012, p. 9

(<http://www.tn.gov/tenncare/forms/quickguide.pdf>). This indicates that methadone treatment and buprenorphine is covered for 18-20 year olds.

“*Pharmacy Non-Covered Items.* The following items are Not Covered, except for children under age 21 or as otherwise noted below...”

“Generic buprenorphine, Subutex (buprenorphine), and Suboxone (buprenorphine/naloxone) in dosage amounts that exceed sixteen milligrams (16 mg) per day for a period of up to six months (which for a pregnant enrollee shall not begin until the enrollee is no longer pregnant), or eight milligrams (8 mg) per day at the end of a six-month period.”

Source: TennCare Quick Guide May 2012, p. 12

(<http://www.tn.gov/tenncare/forms/quickguide.pdf>).

The applicant stated in the supplemental response “applicant will provide documentation to allow patients to make claims to TennCare”. Please discuss this process.

Response: Applicant placed another call to TennCare Solutions at 1-800-878-3192. The representative confirmed that out-of-network claims may be reimbursable. The process explained to the Applicant was that the TennCare member would call this number, answer some questions from TennCare Solutions, and a reimbursement amount, if any, would be determined. The TennCare member would then be given instructions by TennCare Solutions to submit the claim for reimbursement, subject to review by TennCare Solutions. Applicant will provide a sales receipt for all medication and services to allow patients to submit a claim to TennCare but this will be up to the patient to make any and all claims—if in fact reimbursement is available. Applicant will not

offer any warranty or representation about TennCare coverage as to any item of service or medication. Applicant does not intend to make claims on behalf of any patient to TennCare.

3. Section B, Project Description, Item 1

Public Chapter 363 of the Acts of the 2001 General Assembly Methadone Treatment Facilities created Methadone Service Areas (MSAs) on the assumption the closer one lives to a treatment program, the greater likelihood of participation. The rate of participation is nearly twice as high for those living in or near a county that houses a methadone program (59.0/100,000) than the rate for those that live 60 miles or more from a program (32.2/100,000). Please indicate if all population of the proposed service area lives within 60 miles of the proposed project location. If not, what is the percentage that does?

Response: Applicant estimates that 90% of the proposed service area's population is within 60 miles based on using Google directions and the shortest time driving option. The calculations and assumptions are shown below.

Demographic	Population, 2011 estimate	Estimated % within 60 miles	Population within 60 miles	Comment
Sullivan	157,419	100%	157,419	Entire county is within 60 miles
Washington	124,353	100%	124,353	Entire county is within 60 miles
Greene	69,339	100%	69,339	Entire county is within 60 miles
Hamblen	63,062	58%	36,786	Half of Morristown and areas northeast are less than 60 miles
Carter	57,185	100%	57,185	Entire county is within 60 miles
Hawkins	56,671	98%	55,538	Only the lowest southwest portion of the county is greater than 60 miles
Cocke	35,544	10%	3,554	Small population off of exit 12 on I81 is less than 60 miles
Unicoi	18,280	100%	18,280	Entire county is within 60 miles
Johnson	18,231	100%	18,231	Entire county is within 60 miles
Total for service area	600,084	90%	540,685	

The applicant was requested to contact the Department of Mental Health Methadone Authority, Attention Ira Lacey (615-552-7802) to discuss how the

applicant's plans will interact with the DMHDD Methadone Authority's statewide plan. Did the applicant make contact, and if so, please discuss. 9:00 am

Response: The Applicant talked to Mr. Ira Lacy on March 27, 2013. Mr. Lacy understands our position that the opiate abuse and addiction issues in northeast Tennessee warrant attention, and he confirmed there was no comparable treatment in the proposed service area to the treatment services we are proposing. Mr. Lacy explained the licensing and Central Registry procedures.

Further, Applicant's Managing Member had a substantive meeting on March 25, 2013 with the following representatives from the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS): Commissioner Doug Varney, Deputy Commissioner Marie Williams, Director of Licensure Cynthia Tyler, and Director of Legislation Kurt Hippel.

Applicant characterizes the meeting as very positive and potential grounds of agreement were as follows:

- The severe problems of opiate abuse in Tennessee and the proposed service area
- That no opiate treatment programs exist in the proposed service area and many adults drive great distances to get these treatment services in Asheville, Knoxville, Boone, NC and Galax, VA
- Distance is a barrier to treatment
- Applicant's Manager shared his history with proposed treatment services and the vision of TCH to implement these services in the proposed service area.

The scheduled hours of 5:00 AM until noon seven days per week is noted on page 98 of the application. However, on page 109 the Johnson City Zoning Regulations for methadone facilities states "the hours of operation shall be between 7:00 a.m. and 8:00 p.m." Please clarify.

Response: Applicant has requested a zoning variance from Johnson City to accommodate these hours.

Also, the Johnson City Zoning Regulations states, "the facility shall be located on and primary access shall be from an arterial street." How does the applicant intend to address this zoning regulation while the proposed site is located on a cul-de-sac?

Response: Applicant has requested Johnson City grant the Board of Zoning Appeals the authority to grant this arterial road variance. Applicant looked at over 50 sites within the Tri-Cities area and felt that the proposed site best met the needs of the community and patients relative to patient access, traffic, visibility, and distance from schools, daycare, parks.

The types of businesses that surround the proposed methadone project are noted. Are these businesses in support of the proposed project?

Response: There are two other businesses located on Wesley Court, CK Supply and Thomas Construction, both related to construction. Applicant contacted and briefed the landlord/owner of one of the business and this individual voiced no opposition. The landlord of Applicant's proposed property knows the owner/landlord of the other business and has briefed that individual, and this individual has voiced no opposition to date. The Applicant would characterize their responses as neutral.

The size and capacity of the parking lot consisting of 68 spaces is noted. Please clarify if the applicant already owns the space to add 100 parking spaces and street level parking.

Response: The combined parking between 68 on-site which are owned by applicant's landlord can be supplemented at least 12 spaces on the property that can simply have lines painted for standard parking spaces (two on the south side of the building, and ten on the north side. This would make a total of 80 spaces. There are an estimated additional 20 unmarked spaces in front and back of the facility that is on property owned by applicant's landlord. Applicant's ratio of patients to parking spaces after year two would still remain below the ratio of several other existing Tennessee OTPs as shown below.

Tennessee Treatment Program	Patients ¹	Parking spots	Parking spots per patient
Hamilton Co./Volunteer	1963	80	24.5
Davidson Co./Middle Tenn	1789	89	20.1
DRD Knoxville	1063	70	15.2
TCH Johnson City – End of Year 2	1208	80	15.1
Solutions of Savannah	545	46	11.8
TCH Johnson City – End of Year 1	918	80	11.4
DRD Knoxville Central	1035	97	10.7
Jackson Professional Associates	795	102	7.8
Shelby Memphis	741	110	6.7
Shelby Co./ADC	408	75	5.4
Shelby Raleigh	326	60	5.4
Dyer Co.Midsouth	224	50	4.5

What is the timeframe for this project and proposed cost? Is this cost included in the projected data chart?

The Applicant does not feel parking will be an issue, and no costs are reflected in the Projected Data Chart to remedy a parking problem.

4. Section C, Need, Item 1. (Service Specific Criteria-Any)

Please respond to the section labeled "Relationship to Existing Applicable Plans" in Tennessee's Health: Guidelines for Growth, Criteria and Standards for Certificate of Need, 2000 Edition: Non- Residential Methadone Treatment Facilities, Criteria and Standards. Please list each criterion separately and provide a response to each criterion separately immediately following the criterion statement, stating how the proposed project will address/relate to each criterion.

On page 20 of the application the applicant estimates the economic savings to the State to be \$765 per patient per month based on studies in the states of Washington and Tennessee. This study appears to only pertain to Medicaid patients. Did the applicant apply this study to all patients? Please clarify, expand and discuss.

¹ Note: 2008 Tennessee Registry Data

Response: Applicant estimates that 30%-50% of patients are Medicaid-eligible based on the populations at other clinics in which Applicant's Manager is a part owner. This would reduce the total cited on Page 20 accordingly. However, in the report "*Prescription Drug Abuse In Tennessee*" conducted by the Tennessee Department of Health, the study states that the State-funded costs of children of parents who are substance abusers entering state custody and juvenile justice State custody total \$57 million annually. This figure includes all substance abuse, not just opiates, but a) opioid have become the #1 abused drug (as measured by treatment admissions) and has also passed alcohol and b) this does not include any State-funded adult medical costs².

The applicant refers to Attachment C1-A, Tennessee Methadone Service Areas" in responding to service area specific criteria on page 22 of the application. The attachment the applicant is referring to is Attachment C.3. Please revise and submit a revised page 22.

Response: Applicant apologizes for the oversight. See Attachment Revised Page 22, with the correct reference.

5. Section C, Economic Feasibility, Item 1 (Project Costs Chart)

The applicant did not resubmit a Project Costs Chart for the revised supplemental submission. Please submit.

Response: Applicant apologizes for the oversight. See Attachment Project Costs Chart, which should go after page 29, and be page numbered 29A

6. Section C, Economic Feasibility, Item 2

A fax under separate cover documenting financial resources is noted. However, for appropriate documentation please provide a letter from a banking institution, Certified Public Account, etc. that demonstrates financial resources and/or reserves to implement the proposed project.

Response: Applicant submits Attachment Revised Financial Resources from the brokerage account under the control of the Applicant's Manager for purposes of financially securing this project.

7. Section C, Economic Feasibility, Item 4 (Projected Data Chart)

There are two Projected Data Charts with two different financial outcomes in Year Two of the proposed project. Please submit the Projected Data Chart (that includes management fee fields) the applicant intends to attach to this proposed project.

Response: Applicant apologizes for placing the previous Projected Data Chart in the document in addition to the revised Projected Data Chart. See Attachment Projected Data Chart for the correct Projected Data Chart. The previous Projected Data Chart (page 36) can be deleted.

8. Orderly Development Item 1

March 28, 2013

The applicant states, "because of the epidemic levels of prescription medication abuse, Tennessee providers have experienced increases in enrollment." Please provide statistics to back this statement.

Response: *"The Centers for Disease Control and Prevention has classified prescription drug abuse as an epidemic".³* In the Tennessee Department of Health report entitled *"Prescription Drug Abuse In Tennessee"*, on page 14, Tennessee indicates that opioid abuse in Tennessee is materially higher than in the United States, as measured by primary drug abused. Further, the National Survey on Drug Use and Health, 2007-2008 states *"In 2007-2008, Tennessee ranked first among all states for past-year non-medical use of pain relievers among persons age 26 or older."* on page 1.⁴ On page 2, the same report shows a map of the United States and Tennessee is color-coded with the highest percentage of non-medical use of prescription pain relievers. The Applicant contends that if the CDC indicates the problem is an epidemic in the United States, and if Tennessee ranks first among all states in abuse, it is an epidemic in Tennessee.

9. Section C, Orderly Development, Item 6.B

The applicant's methadone fee of \$10.00 per day appears to be considerably less than other surveyed clinics amounts of \$11-\$13, \$16.14 and \$25.00. Please clarify.

Response: This information is correct. Applicant sees tremendous benefit to lowering the barriers to treatment, and cost is a major factor. The Applicant's intent is to offer this rate for a time of 6 months to two years, depending on patient census. In the Applicant's Manager's other clinics in which he owns a partial interest, these clinics had tremendous results "getting the word out" and breaking down barrier to treatment by offering treatment for \$1 per day for periods of six months to over a year.

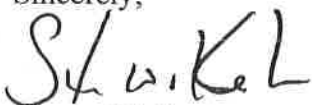
10. Notification Requirements

Please provide a copy of each signed certified mail delivery green card that was sent to public officials in accordance to Tennessee Code Annotated 68-11-1607(c)(3).

Response: The letters to all required persons were sent on or about March 5, 2013 and shown on page 131. The letters were received as shown in the electronic receipt provided on page 136 with tracking numbers. Applicant's attorney used LaserSubstrates, a web-based service to print and track certified letters (<https://www.printcertifiedmail.com>). The Green Cards have not been returned by the Postal Service yet.

Also included is our signed Affidavit.

Sincerely,



Steven W. Kester
Managing Member
Tri Cities Holdings, LLC

³ Direct quote from: <http://www.whitehouse.gov/ondcp/prescription-drug-abuse>

⁴ http://www.whitehouse.gov/sites/default/files/docs/state_profile_-_tennessee.pdf

AFFIDAVIT

2013 MAR 28 AM 9:02

STATE OF GEORGIA

COUNTY OF GWINNETT

NAME OF FACILITY: TRI CITIES HOLDINGS LLC

I, STEVEN W. KESTER, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

St W. Kester
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 27 day of March, 2013, witness my hand at office in the County of Gwinnett, State of Georgia.

Dee Matson
NOTARY PUBLIC

My commission expires Jan. 4, 2016.

HF-0043

Revised 7/02



Response to
Public Chapter 363
of the
Acts of the 2001 General Assembly

Methadone Treatment Facilities

Report prepared by

Tennessee Department of Health
in Consultation with the
Methadone Task Force,
Health Care Facilities Commission and
Board for Licensing Health Care Facilities

TABLE OF CONTENTS

	Page Numbers
Scope of Report.....	1
Report Process.....	2
Background.....	3
National Concerns.....	3
Tennessee Problems.....	4
Tennessee Regulatory Oversight.....	4
Findings of Fact.....	6
Summary.....	8
Recommendations.....	10
Exhibits.....	15
(Note: Exhibits are not available for downloading.)	

SCOPE OF REPORT

Due to the increased attention in the placement of methadone treatment facilities and the need for these facilities, the General Assembly charged the Commissioner of Health to conduct a study of methadone treatment facilities and report back to the House Health and Human Resources Committee and the Senate General Welfare, Health and Human Resources Committee on or before January 1, 2002.

Public Chapter 363 of the Acts of the 2001 General Assembly directs the Commissioner of Health to study issues relating to the need for and location of non-residential treatment facilities in the Certificate of Need process in consultation with the Health Facilities Commission and the Board for Licensing Health Care Facilities.

This report will contain reviews conducted of current federal and state regulations of methadone treatment facilities, state oversight of Tennessee facilities, literature on national concerns, regulations from other states, and reports from the Tennessee Board of Pharmacy.

To the extent possible, recommendations will be based on a thorough review of all data, nationally accepted facts, and practice standards of methadone facilities.

This report includes recommendations to current regulations utilized by state survey agencies and *Guidelines for Growth* used by the Health Facilities Commission in making decisions about need.

REPORT PROCESS

This study was conducted in monthly meetings with committee members being appointed by the Commissioner of Health. Monthly meetings were conducted on September 27, 2001, October 23, 2001, November 13, 2001, and December 18, 2001. A membership list is attached in the exhibits.

Task force members and Health Facilities Commission members were given an opportunity to review the draft report in order to make comments and suggestions prior to finalizing the report.

Some members expressed concerns about the proposed rule changes dealing with:

- 1) Observed testing and
- 2) Diversion Control Plan

These comments are attached in exhibits. (**Note: Exhibits are not available for downloading.**)

BACKGROUND

National Concerns

The November 1997 *National Institutes of Health Consensus Statement, Effective Medical Treatment of Opiate Addiction* estimated that only 115,000 of the total 600,000 estimated opiate-dependent persons in the U.S. were in methadone maintenance treatment (MMT) programs. The Consensus Statement reported that, "MMT is effective in reducing illicit opiate drug use, in reducing crime, in enhancing social productivity, and in reducing the spread of viral diseases such as AIDS and hepatitis." Although a totally drug-free state would be preferable, most opiate-dependent persons, according to research, cannot achieve and maintain this worthy target. MMT, as a substitute for a drug-free state, does reduce drug use, decrease criminal activity, provide an opportunity for employment and significantly improve quality of life for patients.

Opiate use has clear and well-defined health, employment and criminal consequences according to the Consensus Statement. The total financial costs of untreated opiate dependence to the individual, family and society was estimated at \$20 billion by the NIH in its Consensus Statement. Numerous studies throughout the world have demonstrated that participation in MMT leads to significant reductions of illegal opiate use as well as other illicit drugs.

The mortality rate for opiate-dependent persons in methadone treatment programs is 30% of the mortality rate for those not participating in treatment. Persons who are not participating in MMT have higher incidence rates of bacterial infections, tuberculosis, hepatitis B and C, AIDS and other sexually transmitted diseases and alcohol abuse. Health care costs alone were estimated in the 1997 Consensus Statement to amount to \$1.2 billion for opiate dependence.

Opiate use has an adverse impact upon employment and an individual's contribution to society. Since users spend an inordinate amount of time in finding and taking the drug, maintaining employment is often difficult. Many users look to public assistance to support themselves and their families. Studies have demonstrated, however, that MMT patients earn incomes that are double those of opiate users not in treatment.

Opiate use often leads users to criminal behavior. Stealing is the most common offense. The Consensus Statement reports that more than 95% of opiate users reported committing crimes in span of an 11-year period when they were using opiates. Numerous studies have demonstrated that "effective treatment of opiate dependence markedly reduces the rates of criminal activity."

Many persons associate dependency solely on heroin use. Too often, legally prescribed controlled substances, including opiates such as hydrocodone and morphine, are diverted for illegal use. In fact, the February 2001 edition of the *Psychiatric Times* reported that a national Substance Abuse and Mental Health Services Administration (SAMHSA) survey indicated that approximately 3.9 million Americans currently use prescription-type psychotherapeutic drugs for nonmedical reasons, almost twice as many as the 2.1 million who use heroin, cocaine and/or crack cocaine.

The NIH Consensus Statement addresses many of the misconceptions and stigmas associated with opiate dependence and methadone treatment programs. NIH urges that “vigorous and effective leadership is needed to inform the public that dependence is a **medical disorder** (emphasis added) that can be effectively treated with significant benefits for the patient and society.”

Tennessee Problems

No public health data exist which accurately depicts the extent or severity of opiate addiction in Tennessee. Extrapolating the NIH estimates to Tennessee provides as reasonable an approach as any, resulting in estimates that 12,000 or more Tennesseans are opiate dependent. In December 2001, less than 3,000 persons were actively participating in non-residential treatment programs in the state which represents only a fraction of the state’s estimated opiate users.

Generally, the closer one lives to a treatment program, the greater likelihood of participation. The current rate of participation is nearly twice as high for persons living in or close to one of the five counties (Shelby, Davidson, Knox, Hamilton and Madison) that house programs, 59.0/100,000 than the rate for those that live 60 miles or more from a program, 32.2/100,000.

The relatively few number of programs in the state that are available to opiate-dependent persons also contributes to low participation rates. Although the number of programs in other Southeastern states varies widely, Tennessee’s six programs yields a rate of just 1.1 programs/one million population, less than one-half the 2.4/one million rate of the other states.

As is true around the country, substance abuse probably cannot be attributed solely to illegal substances in this state. Although Tennessee does not maintain a system for capturing data on the number of prescriptions filled, vendors in Tennessee cite the state as one of the top five in the country for purchase of Hydrocodone, Cocaine and Meperidine, all controlled substances that are easily diverted for illegal use.

Tennessee Regulatory Oversight

Tennessee Code Annotated requires that a vendor wanting to open a methadone treatment program must first receive a Certificate of Need from the Tennessee Health Facilities Commission and then be licensed by the Department of Health as a non-residential methadone treatment facility. Unfortunately, the *Guidelines for Growth* that have been developed do not provide concrete, objective criteria that can be used to adequately determine the appropriateness of awarding a Certificate of Need.

The regulatory oversight of Methadone Treatment Facilities began in 1988 by the Tennessee Department of Mental Health. In March, 1994 that oversight was transferred to the Department of Health, Health Care Facilities. Rules and regulation were amended by the Department in August, 1999 with encouragement and support of the General Assembly.

Currently there are 6 clinics operating in Tennessee in the following counties: Shelby, Davidson, Knox, Hamilton and Madison. Each clinic is surveyed annually and as necessary when complaints are filed.

For the past 2 years an average of 2 deficiencies have been sited per survey and consist of:

- No Individual Treatment Record
- Client history and treatment plans not reviewed every 90 days
- No documentation of staff training for STD/HIV Training
- Admission screening test not done – TB test, and pregnancy test for females
- No annual justification for continued treatment
- No evidence of annual physical
- Urine drug screens not conducted on new clients
- No physician's signature on medication order changes

There have been 3 complaints filed in the past two years.

FINDINGS OF FACT

During the review of the vast amount of materials and interviewing of individuals, the following facts were formulated and agreed upon by the panel:

- ❖ Businesses that establish programs require a general population of at least 100,000 persons from which to draw potential clients. This figure is believed to generate 67 clients on average. Private businesses normally will not establish a program unless a minimum caseload of 60 patients is available.
- ❖ The closer one lives to a treatment program, the greater likelihood of participation as based on current participation in Tennessee Methadone Treatment facilities—
 - 59.0/100,000 population participate in programs 60 miles or less
 - 32.2/100,000 population participate in programs over 60 miles
- ❖ The NIH Consensus Statement of November, 1997 estimated that only 115,000 of the total 600,000 estimated opiate-dependent persons in the U.S. were in methadone maintenance treatment programs.
- ❖ Applying the NIH 1997 Consensus statement estimates of approximately 20% of opiate-dependent persons to Tennessee Census data, the number of potential clients could be as high as 12,300 within the state indicating only a fraction of the opiate users in the state are currently participating in methadone treatment programs.
- ❖ The financial costs of untreated opiate dependence to the individual, family and society was estimated at \$20 billion by the NIH in its Consensus Statement.
- ❖ Opiate use has clear and well-defined health consequences. The mortality rate for opiate-dependent persons in methadone treatment programs is 30% lower than for dependent persons not participating in treatment. Numerous studies have demonstrated that participation in methadone maintenance treatment programs (MMT) leads to significant reductions of illegal opiate use as well as other illicit drugs.
- ❖ Since no data exists otherwise, it was presumed that the prevalence of opium-dependence was similar throughout the state.
- ❖ From a public policy standpoint, placing persons in a nonresidential methadone treatment program is preferable than allowing persons to remain addicted to heroin or other opiates.
- ❖ All Tennesseans who are eligible for and choose to participate in nonresidential methadone treatment should have reasonable geographic access to a program.
- ❖ Access should allow participants to develop a life that could include full employment and meaningful contributions to society.

- ❖ The number of reported methadone treatment facilities per SAMHSA in neighboring states varies widely:

<u>STATE</u>	<u>#</u>	<u>Rate/one million population</u>
Alabama	17	3.8
Arkansas	3	1.1
Georgia	24	2.9
Kentucky	15	3.7
Mississippi	2	.7
Missouri	12	2.1
North Carolina	18	2.7
Tennessee	6	1.1
Virginia	14	2.3

SUMMARY

In response to Public Chapter 363 of the Acts of 2001, the Commissioner of Health assembled a Methadone Task Force comprised of persons interested and involved in the subject of Methadone Maintenance Treatment (MMT). This task force held several meetings between September 1, 2001 and December 21, 2001 and examined a vast array of information related to Methadone programs, both in Tennessee and throughout the country. Many items that were considered by the group are attached to this report as exhibits.

New federal regulations for MMT were implemented on March 19, 2001. The task force examined the differences in existing Tennessee regulations and the new federal regulations in an effort to determine what changes were needed to the state's regulations for Non Residential Narcotic Treatment Facilities in order to assure compliance and compatibility with the new federal guidelines. In addition to reviewing the new federal regulations, the group reviewed other state regulations for comparison as well. Suggestions and comments were solicited from the methadone industry, methadone treatment specialists and the Department's Bureau of Alcohol and Drug Abuse Services for input on recommendations that would best serve to protect the public health, safety and welfare of the citizens of Tennessee.

Information from the state's Central Registry of Methadone patients in treatment was compiled, analyzed and studied by members of the group. Both the number and participation rate of active patients in treatment per county of residence was determined. Distance was a strong predictor of participation rates. Assuring that all Tennesseans who wish to participate in MMT have reasonable access to a program was used as justification for planning purposes of the proposal to designate 23 Methadone Service Areas (MSA) within the state. An MSA is a county or constellation of contiguous counties in the state that comprise a sufficient general population making it likely that a minimum number of opiate dependent persons reside in the MSA who wish treatment and could support a program. This minimum population foundation was balanced with the need to establish geographic boundaries such that patients living within the MSA would reside within less than an hour drive one-way to a treatment program if the program were established in the heart of the MSA. Refer to exhibit #6 for proposed MSAs.

The Tennessee Board of Pharmacy provided to the panel the DEA's Retail Drug Distribution by Zip Code report for Tennessee. This detailed report showed what prescription drugs were being shipped to various areas of the state. Also provided to the group was the information that revealed Tennessee's ranking in the purchasing of legally prescribed drugs. This report revealed Tennessee in the top five nationally for the purchase of Cocaine, Hydrocodone, and Meperidine (Demerol), each of which can be readily converted to illicit use that contributes to the high rate of opiate dependency in the state.

Although the current Guidelines for Growth were adopted by the Department and the Health Planning Commission in 2001, they still remain vague and lack the specificity as needed to support the philosophy of directing the delivery of health care services for methadone treatment. The group reviewed the current criteria and standards used for assisting the Health Facilities Commission in decisions concerning certificate of need application and felt improvements should be made.

Incorporating the concept of the Methadone Service Areas (MSAs), adding distance in travel time to existing programs and the impact on employment opportunities would strengthen the quality of the information submitted to the Commission when agencies request a Certificate of Need (CON). More comprehensive information would contribute to better decisions relating to need, economic feasibility, and orderly contribution to development of adequate and effective methadone treatment programs and assist the Department and the Health Facilities Commission in determining the appropriateness of issuing a CON.

RECOMMENDATIONS

As a result of these efforts the Task Force is issuing recommendations within this report relating both to proposed rules changes and changes to the Guidelines for Growth. These recommendations follow in the papers titled “Proposed Rule Amendments to Chapter 1200-8-21 Non-Residential Narcotic Treatment Facilities” and “Guidelines for Growth Proposed Amendments”.

Recommendations of the Methadone Task Force
December 2001

Proposed Rule Amendments to Chapter 1200-8-21 Non- Residential Narcotic Treatment Facilities

1200-8-21-.01 Definitions.

Recommendation: Add the following definitions:

1. Counseling Session. Therapeutic discussion between client(s) and a facility counselor for a period of no less than thirty (30) minutes designed to address client addiction issues or coping strategies and treatment plans.

Rationale: *Establishes a minimum standard for a counseling session*

2. Observed Testing. Testing conducted and witnessed by a facility staff person to ensure against falsification or tampering of results of a drug screen.

Rationale: *Clarification of testing procedure.*

3. Random Testing. Drug screens conducted by the facility that lack a definite pattern of who and when clients are selected for testing; indiscriminate testing.

Rationale: *Clarification of current regulatory language.*

4. Relapse. The failure of a client to maintain abstinence from illicit drug use verified through drug screen.

Rationale: *To clarify proposed amended language.*

1200-8-21-.02 Licensing Procedures.

Recommendation: Propose amending the following:

1200-8-21-0.2(2)(a). Delete ... “rules of the FDA...” and replace with “...rules of SAMSHA (Substance Abuse and Mental Health Services Administration)...”

Rationale: *This change allows Tennessee's regulations to be aligned with those guidelines from the Federal agency, as they have been in the past.*

1200-8-21-.04 Administration.

Recommendation: Propose amending the following:

1. 1200-8-21-.04(4)(f) Counselors. Delete current language and replace with the following:
There must be sufficient group and individual counseling available to meet the needs of the client population. At a minimum, the following counseling schedule shall be followed:
 - (i) During 1st 90 days of treatment, counseling session(s) shall take place at least one time a week;
 - (ii) During 2nd 90 days of treatment, counseling session(s) shall take place at least three (3) times per month;
 - (iii) During the 3rd 90 days of treatment, counseling session(s) shall take place at least two (2) times per month;
 - (iv) For subsequent 90 day periods of treatment, counseling session(s) shall take place as needed or indicated in the client's treatment plan, but no less frequent than monthly as long as the client is compliant;
 - (v) If the client experiences a relapse, his/her individualized treatment plan must document evidence of intensified services provided. Such evidence may include, but is not limited to, increase in individual or group counseling session(s) and/or a reduction in the client's take home privileges.

Rationale: *A specific counselor to client ratio has proven to be a difficult item to measure and does not dictate the quality of counseling provided. This change is directed at establishing the minimum standard and reflects the Federal change to accreditation rather than regulation. This should allow more flexibility for the clinics to establish quality counseling programs that achieve the desired outcomes necessitated for accreditation.*

2. 1200-8-21-.04(21). Hours of Operation. Propose amending the following:
Delete the third sentence that states, "In order to accommodate clients who are not receiving take-home medication, facilities must be open for dispensing seven days per week."
Replace with: Any patient in comprehensive maintenance treatment may receive a single take-home dose for each day that the clinic is closed for business, including Sundays and State and Federal holidays, not to exceed two (2) consecutive days.

Rationale: *Would potentially result in improved client compliance and an orderly provision of services.*

3. 1200-8-21-.04, (f) 24.

Propose adding the following language:

A Diversion Control Plan shall be in place at each clinic. The Diversion Control Plan must contain, at a minimum, the following:

- (i) The Diversion Control Plan shall apply to all clients receiving take home medication.
- (ii) It will include a random call back program with mandatory compliance. This call back must be in addition to the regular schedule of clinic visits.

- (iii) Each client receiving take-home medications must be called back at a minimum of once per 3 months.
- (iv) Upon call back a client must report to the clinic within 24 hours of notification, with all take home medications. The quantity and integrity of packaging shall be verified. One dose must be replaced and sent for analysis to verify strength and contents.
- (v) The facility shall maintain individual callback results in the client record.
- (vi) The facility must maintain a current log of all callbacks with the results of compliance.

Rationale: *Methadone diversion is always a concern both from the clinic standpoint and in the community in which it is located. This rule establishes minimum standards and requires each facility to develop callback plans for diversion control. .*

1200-8-21-.05 Admissions, Discharges and Transfers.

Recommendation: Propose to amend the following:

1. 1200-8-21-.05(4)(a) Amend third sentence to read, “Within 72 hours of admission **or discharge**, the facility shall initiate a clearance inquiry by submitting to the approved central registry the name, date of birth, anticipated date of admission **or discharge**...”

Rationale: *In order for the Central Registry to remain current in information, the SNA must be notified of discharges as well as admissions.*

2. Add the following language: The facility shall ensure that clients are instructed in the proper storage and security of take-home medications after they leave the facility.

Rationale: *To provide for the safe storage and handling of take-home medications to protect general welfare of the public.*

1200-8-21-.06 Basic Services.

1. 1200-8-21-.06(5)(h).

Recommendation: Add the following language:

Each clients’ individualized treatment plan must include the counseling needs, including both group and individual counseling sessions as indicated by evaluation of the client’s length of time in the program, drug screening results, progress notes, and social environment. The treatment plan must be reviewed at least every six (6) months.

2. 1200-8-21-.06(8)(a). Drug Screens. Delete the word Urine.

Rationale: *This will allow the use of alternative drug screening at the discretion of the clinic. There are alternative tests available such as saliva and hair that are less invasive for the client, less opportunity for dilution/contamination. Currently they are prohibited from use in Tennessee because this regulation only recognizes urine drug screening*

3. 1200-8-21-.06(9)(c) Take Home Doses. Amend by adding ... “methadone **and LAAM**”

Rationale: *This allows Tennessee regulations to be in conformity with the Federal Regulations.*

4. 1200-8-21-.06 (9) (c)

Recommendation: Propose amending the following:

... “rules of the FDA...” and replace with “...rules of SAMSHA (Substance Abuse and Mental Health Services Administration)...”

Rationale: *This change allows Tennessee’s regulations to be aligned with those guidelines from the Federal agency, as they have been in the past.*

Guidelines for Growth-proposed amendments

1. Need determinations for non-residential methadone treatment facilities shall strongly consider the Methadone Service Area. [Methadone Service Areas (MSAs) are designated for planning purposes to assist the state agencies in determining the appropriateness of issuing a Certificate of Need. These MSAs were developed in response to assumptions developed by a committee established in response to Public Health Chapter 363 of the Acts of 2001.]

Designation of MSAs was patterned, in concept, after the use of Rational Service Areas by the Department of Health in helping identify underserved health resource shortage areas in Tennessee. An MSA is a county or constellation of contiguous counties in the state that comprise a sufficient general population making it likely that a minimum number of opiate dependent persons reside in the MSA who wish treatment and could support a program. This population foundation was balanced with the need to establish geographic boundaries such that patients living within the MSA would reside within less than an hour drive one-way to a treatment program if it were established in the heart of the MSA. Assumptions that guided determination of MSAs:

- Generally, the closer one lives to a treatment program, the greater likelihood of participation. The rate of participation is nearly twice as high for persons living in or close to one of the five counties that house programs, 59.0/100,000 than the rate for those that live 60 miles or more from a program, 32.2/100,000
- Businesses that establish programs require a general population of no less than 100,000 persons from which to draw potential clients. This figure is believed to generate 67 clients on average. Private businesses normally will not establish a program unless a minimum caseload of 60 patients is available.
- In order to assure a sufficient population base in each MSA to support a treatment program, boundaries of MSAs were drawn to include a general population of 200,000. (Identification of MSAs with less population, e.g. 150,000, led to some areas with barely sufficient population to support a program; more than 200,000 would perpetuate distance barriers to existing programs.)

2. Decisions should be predicated upon improving access to programs that will increase patient compliance and reduce dropout rates and recidivism.

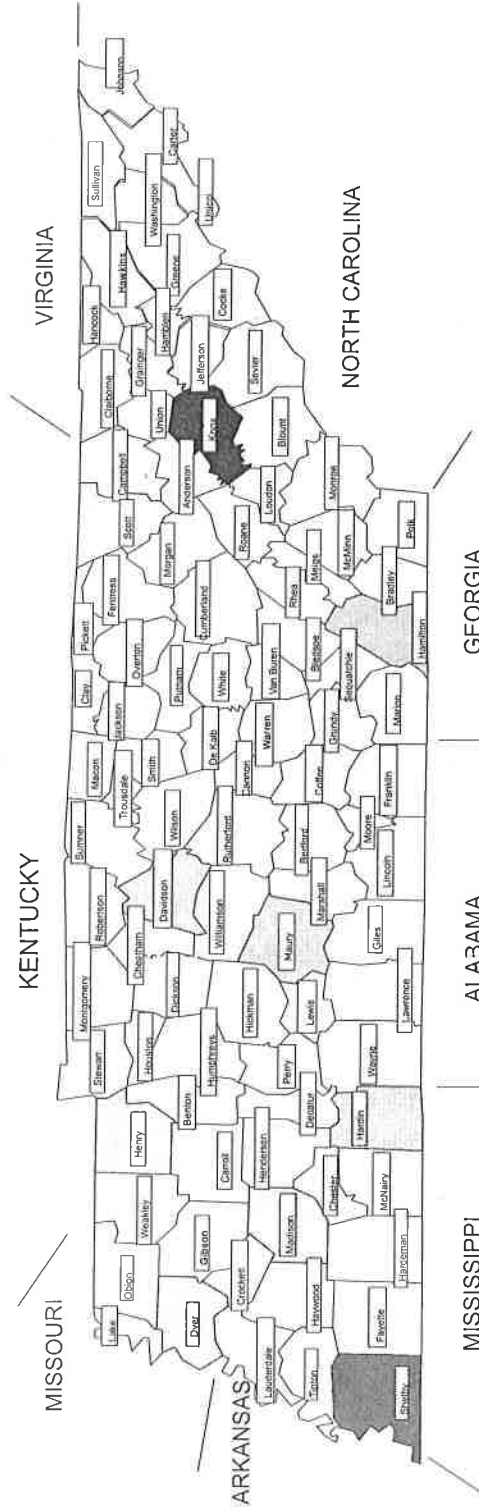
3. Access determinations should include the distance in miles and approximate travel time to the nearest existing programs. Consideration should be given to the quality of life improvements and employment opportunities available if programs were geographically accessible.
4. Strong consideration should be given to an applicant in a multi-county MSA without an existing program if Need, Economic Feasibility and Contribution to Orderly Development are met.
5. Simultaneous review CON applications for programs in the same MSA or a CON application in an MSA where at least one program already exists should demonstrate:
 - Current and potential caseloads
 - Estimated current unmet needs
 - Prospects for long-term viability if multiple programs are approved
 - Experience of the applicant in other locations (in- or out-of-state)
6. The applicant shall provide documentation on any agency in- or out-of-state with which the applicant has legal interest in or is involved in a management role.
7. The Department of Health's application review (TCA 68-11-107) will include recommendations from the State Methadone Authority. Both the Department and the Commission shall consider the State Methadone Authority's quarterly Tracking Report (description of patient census by county of residence).

Exhibits**(Note: Exhibits are not available for downloading.)**

Exhibit 1	Committee Members
Exhibit 2	Public Chapter 363
Exhibit 3	Non Residential Narcotic Treatment Facility Outcome/Performance Data 1997, 1998, 1999 & 2000
Exhibit 4	Methadone Registry
Exhibit 5	County 2000 Population
Exhibit 6	Possible Methadone Service Areas for NR Methadone Clinic Locations
Exhibit 7	Map
Exhibit 8	Non-Residential Methadone Treatment Facilities (NRMTF)
Exhibit 9	Federal State
Exhibit 10	Chapter 1200-8-21 Rules for Alcohol and Other Drugs of Abuse Non-Residential Narcotic Treatment Facilities
Exhibit 11	Federal Register
Exhibit 12	Retail Drug Distribution
Exhibit 13	1999 Highlights
Exhibit 14	Certificate of Need and Rule Revision Recommendations
Exhibit 15	Volunteer Treatment Center, Inc.

G6022004/BHLR

Tennessee Opioid Treatment Clinics



○ ONE LOCATION ● TWO LOCATIONS ● THREE LOCATIONS

- | | |
|--|---|
| <p>Shelby (Memphis)
ADC Recovery & Counseling Center
3041 Getwell, Suite 101
Memphis, TN 38118
(901) 375-1050
Hours of Operation M-F 5a-1:30p; Sat 6a-9a
Dosing Hours M-F 5:30a-11a; Sat 6a-9a</p> | <p>Hamilton (Chattanooga)
Volunteer Treatment Center, Inc.
2347 Rossville Blvd
Chattanooga, TN 37408
(423) 265-3122
Hours of Operation M-Sat 5:30a-2p
Dosing Hours M-F 5:30a-12:30p; Sat 5:30-11a</p> |
| <p>Memphis Center for Research & Addiction
1270 Madison Ave
Memphis, TN 38104
(901) 722-9420
Hours of Operation M-F 5:45a-2p; Sat 6a-9a
Dosing Hours M-F 5:45a-1p; Sat 6a-9a</p> | <p>Knox (Knoxville)
DRD Knoxville Medical Clinic-Central
412 Citico Street
Knoxville, TN 37921
(865) 522-0661
Hours of Operation M-Sat 5:30a-2:30p
Dosing Hours 5:30a-11p; Sat 6a-9a</p> |
| <p>Raleigh Professional Associates
2960-B Austin Peay Hwy
Memphis, TN 38128
(901) 372-7878
Hours of Operation M-F 5a-1p; Sat 6a-2p
Dosing Hours M-F 5a-9a; Sat 6a-10a</p> | <p>DRD Knoxville Medical Clinic-Bernard
626 Bernard Avenue
Knoxville, TN 37921
(865) 522-0161
Hours of Operation M-Sat 5:30a-2:30p
Dosing Hours M-F 5:30a-11a; Sat 6a-9a</p> |
| <p>Madison (Jackson)
Jackson Professional Associates
1869 Hwy 45 Bypass, Suite 5
Jackson, TN 38305
(731) 660-0880
Hours of Operation M-F 5a-1p; Sat 6a-2p
Dosing Hours M-F 5a-1p; Sat 6a-2p</p> | <p>Hardin (Savannah)
Solutions of Savannah
85 Harrison Street
Savannah, TN 38372
(731) 925-2767
Hours of Operation M-Sat 5:30a-12p
Dosing Hours M-F 5:30a-11a; Sat 6a-9a</p> |
| <p>Henry (Paris)
Paris Professional Associates
2555 East Wood Street
Paris, TN 38242
(731) 641-4545
Hours of Operation M-Sat 5a-1p
Dosing Hours M-Sat 5a-1p</p> | <p>Maury (Columbia)
Recovery of Columbia
1202 South James Campbell Blvd.
Columbia, TN 38401
(931) 381-0020
Hours of Operation M-Sat 5:30a-11a
Dosing Hours M-F 5:30-11a; Sat 6a-9a</p> |
| <p>Davidson (Nashville)
Middle Tennessee Treatment Center
2410 Charlotte Avenue
Nashville, TN 37203
(615) 321-2575
Hours of Operation M-Sat 6a-1p
Dosing Hours M-F 6a-1p; Sat 6a-9a</p> | |

RE: Confirmation of delivery

Mark Farber

Sent: Friday, March 08, 2013 11:14 AM

To: Steve Kester [swkester@gmail.com]

Mr. Kester,

Please accept this email as confirmation that your application has been received.

Mark Farber
Deputy Director
Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

*Included proof of publication
with address of 4 Wesley Court
MF*

615-741-2364 (office)

615-741-9884 (fax)

Mark.Farber@tn.gov (email)

www.tn.gov/hsda (website)

From: Steve Kester [swkester@gmail.com]

Sent: Friday, March 08, 2013 8:50 AM

To: Mark Farber

Subject: Confirmation of delivery

Mr. Farber:

According to Fed Ex's website, you should have received our Application and an original affidavit today.

We're just checking to make sure they arrived?

Thank you and we look forward to working with your office.

Have a good weekend,

Steve Kester
404-664-2616



STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
601 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243-0675

BILL HASLAM
GOVERNOR

E. DOUGLAS VARNEY
COMMISSIONER

MEMORANDUM

TO: Melanie Hill, Executive Director
Health Services and Development Agency

FROM: Sandra Braber-Grove, Director, Office of Contracts and Privacy / Assistant
General Counsel
TDMHSAS Division of General Counsel *Sandra Braber-Grove*

DATE: June 11, 2013

RE: Review and Analysis of Certificate of Need Application
Tri-Cities Holdings LLC d/b/a Trex Treatment Center - CN1303-005

Pursuant to and in accordance with Tennessee Code Annotated (TCA) § 68-11-1608 and Rules of the Health Services and Development Agency including the Criteria and Standards for Certificate of Need (2000 Edition, Tennessee's Health Guidelines for Growth, prepared by the Health Planning Commission) [hereinafter Guidelines for Growth], staff of the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), the licensing agency, have reviewed and analyzed the above-referenced application for a Certificate of Need.

Attached is the TDMHSAS report. At a minimum and as noted in TCA § 68-11-1608, the report provides:

- (1) Verification of application-submitted information;
- (2) Documentation or source for data;
- (3) A review of the applicant's participation or non-participation in Tennessee's Medicaid program, TennCare or its successor;
- (4) Analyses of the impact of a proposed project on the utilization of existing providers and the financial consequences to existing providers from any loss of utilization that would result from the proposed project;
- (5) Specific determinations as to whether a proposed project is consistent with the state health plan; and
- (6) Further studies and inquiries necessary to evaluate the application pursuant to the rules of the agency.

If there are any questions, please contact me at (615) 532-6520.

cc: E. Douglas Varney, Commissioner, TDMHSAS
Marie Williams, Deputy Commissioner, TDMHSAS
Dr. Jason Carter, Pharm. D., TDMHSAS, Chief Pharmacist and State Opioid Treatment Authority (SOTA)
Cynthia Clark Tyler, Director of Licensure, TDMHSAS

REVIEW AND ANALYSIS CERTIFICATE OF NEED APPLICATION # CN1303-005

Pursuant to and in accordance with Tennessee Code Annotated (TCA) § 68-11-1608 and Rules of the Health Services and Development Agency including the Criteria and Standards for Certificate of Need (2000 Edition, Tennessee's Health Guidelines for Growth, prepared by the Health Planning Commission) [hereinafter Guidelines for Growth], staff of the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), the licensing agency, have reviewed and analyzed the application for a Certificate of Need submitted by Mr. Steven W. Kester on behalf of Tri-Cities Holdings, LLC for the establishment of a new "outpatient opiate treatment program (OTP)" (also referred to as a "Non-Residential Substitution-Based Treatment Center for Opiate Addiction"; "Opioid Treatment Program" (OTP); or "methadone clinic"). The Applicant proposes to establish the facility at 4 Wesley Court in Johnson City, Washington County, Tennessee.

The report has three (3) parts:

- A. Summary of Project
- B. Conclusions
- C. Analysis - in three (3) parts:

<u>Need</u>	<u>Economic Feasibility</u>	<u>Contribution to the Orderly Development of Health Care</u>
<p>Evaluated by the following general factors:</p> <ul style="list-style-type: none"> a. Relationship to any existing applicable plans; b. Population to be served; c. Existing or Certified Services or Institutions; d. Reasonableness of the service area; e. Special needs of the service area population (particularly women, racial and ethnic minorities, and low-income groups); f. Comparison of utilization/ occupancy trends and services offered by other area providers; g. Extent to which Medicare, Medicaid, and medically indigent patients will be served; and h. Additional factors specified in the Tennessee's Health Guidelines for Growth publication for this type of facility. 	<p>Evaluated by the following general factors:</p> <ul style="list-style-type: none"> a. Whether adequate funds are available to complete the project; b. Reasonableness of costs; c. Anticipated revenue and the impact on existing patient charges; d. Participation in state/federal revenue programs; e. Alternatives considered; f. Availability of less costly or more effective alternative methods; and g. Additional factors specified in the Tennessee's Health Guidelines for Growth publication. 	<p>Evaluated by the following general factors:</p> <ul style="list-style-type: none"> a. Relationship to the existing health care system (i.e., transfer agreements, contractual agreements for health services, and affiliation of the project with health professional schools); b. Positive or negative effects attributed to duplication or competition; c. Availability and accessibility of human resources required; d. Quality of the project in relation to applicable governmental or professional standards; and e. Additional factors specified in the Tennessee's Health Guidelines for Growth publication.

A. SUMMARY OF PROJECT

Mr. Steven W. Kester (identified as the Managing Member or Manager) has submitted, on behalf of Tri-Cities Holdings, LLC d/b/a/ Trex Treatment Center (Applicant), an application for a Certificate of Need seeking the establishment of a new "outpatient opiate treatment program (OTP)" to be located at 4 Wesley Court in Johnson City, Washington County, Tennessee. An "outpatient opiate treatment program" is also referred to as a "Non-Residential Substitution-Based Treatment Center for Opiate Addiction"; "Opioid Treatment Program" (OTP); or "methadone clinic". On the Applicant Profile, for Type of Institution (Item 7.), the Applicant selected "Non-Residential Methadone Facility" (Item 7.N.). The purpose of review is "New Institution" (Item 8.A.).

The Applicant reports that its Manager is the co-founder and part-owner of nine (9) treatment programs, but information provided in the application [Supplemental #1, Page 4] names only seven (7): two (2) in the Asheville area (Crossroads Treatment Centers of Weaverville, NC and Asheville); three (3) more in Asheville (Western Carolina, CRC, and Mountain Area Recovery Center); and two (2) in Boone, NC (Stepping Stone and McLeod).

If the Certificate of Need application is approved and all other requirements are met, the facility would be licensed by the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). Information provided in the application indicates that it is anticipated that the facility will use buprenorphine, methadone, and abstinence-based treatment for "those suffering from opiate addiction." [Supplemental #1, Page 4] Applicant also reports that the facility will offer individual counseling services and group therapy to "help break the cycle of addiction and provide patients the life skills and resources to serve as productive members of their communities, families and employers." [Supplemental #1, Page 4] The Applicant reports that the commitment will be "to give patients their independence back as soon as medically, morally and ethically possible." [Supplemental #1, Page 4]

The Applicant reports that the proposed service area is the nine (9) most northeastern counties of Tennessee: Sullivan, Washington, Greene, Hamblen, Carter, Hawkins, Cocke, Unicoi, and Johnson, which reportedly covers 100% of the population of Tennessee's Methadone Service Area (MSA) #1, 97% of MSA #2, and 70% of MSA #3. The Applicant further reports that six hundred (600) patients from Northeast Tennessee travel to the Asheville facilities for services, and an admissions counselor at the Knoxville facility (owned by the Behavioral Health Group) indicated, in a phone call placed by the Applicant's Manager on February 25, 2013, that "nearly four hundred (400)" patients from Northeast Tennessee are served in their facility. [Supplemental #1, Page 4]

The Applicant reports that there is no major medical equipment involved in the project other than the dispensing devices used to correctly administer medication doses. The Applicant reports that the proposed building on the proposed site (at 4 Wesley Court) expected to be used for the facility requires no structural modifications, but will be

renovated as follows: the lobby will be re-purposed as a waiting room; large rooms will be partitioned to create offices for counselors, doctors, and the Executive Director; other large rooms will be partitioned and have plumbing added for use as examination and lab rooms; dosing rooms and associated dosing windows will be constructed; a room for the pharmacy and associated medicine vault will be constructed; a check-in booth will be constructed; and electrical, cabling, video, and telephony will be added in/for all rooms. [Supplemental #1, Page 6] The Applicant also reports that the total estimated project cost is \$670,000.00 which includes \$320,000.00 for facility costs [lease at an average of \$5,333.00 per month]; \$160,000.00 for preparation of site costs; \$80,000.00 for "operating loss carry" which was explained as the amount that needs to be financed during the time between when the facility opens until it becomes cashflow positive; and \$30,000.00 for legal, administrative, and consultant fees which the Applicant reported includes accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF). If the application is approved, the anticipated date construction (renovation; approved for occupancy) will be 100% complete is November 2013 with the issuance of a license occurring in January 2014 and the initiation of services occurring in February 2014.

B. CONCLUSIONS

As previously stated, if the application is approved and all other requirements are met, the facility would be licensed by the TDMHSAS. TDMHSAS staff have reviewed and analyzed the application and cannot support approval of the application because the majority of the Criteria and Standards for the type of facility being proposed in the application have not been met as explained below:

1. A note about specific criteria for a non-residential methadone facility. In addition to the other general criteria, the application for a Certificate of Need for a non-residential methadone facility should also address these and other specific criteria as listed in the Guidelines for Growth: 1) A non-residential methadone facility should provide adequate medical, counseling, vocational, educational, mental health assessment, and social services to patients enrolled in the program with the goal of the individual becoming free of opioid dependency; 2) Need should be based on information prepared by the Applicant which acknowledges the importance of considering the demand for services along with need as well as addressing and analyzing service problems; 3) The need assessment should also cover the proposed service area and include the utilization of existing service providers, scope of services provided, patient origin, and patient mix; 4) The Applicant should show that the geographic service area is reasonable and based on an optimal balance between population density and service proximity and show that the project is sensitive and responsive to the special needs of the service area in terms of accessibility to consumers, particularly women, racial and ethnic minorities, and low-income groups; and 5) The Applicant should show the project's relationship to policy as formulated in local and national plans, including need methodologies.

2. Need has not been clearly established as described in further detail in Section C.1. Overall, need has not been clearly established. The Applicant takes national projections and applies them to Tennessee and specifically Upper Northeast, Tennessee resulting in a misrepresentation of need. As mentioned in Section B.1., in addition to the general factors noted on Page 2 of this report, there are additional specific criteria for the type of facility proposed in the application under review. Many of the conclusions and inferences drawn by the Applicant from cited references are not scientifically based and national studies and statistics are mis-applied to the Upper Northeast, Tennessee area. The Applicant reports that the distance required to travel to treatment is a barrier to treatment and provides some statistics on distances from counties within the proposed service area to one of the existing clinics in Asheville, NC as well as the Knoxville, TN clinic. It is also reported that six hundred (600) patients from Northeast Tennessee travel to the Asheville, NC facilities for services, and an admissions counselor at the Knoxville, TN facility (owned by the Behavioral Health Group) indicated, in a phone call placed by the Applicant's Manager on February 25, 2013, that "nearly four hundred (400)" patients from Northeast Tennessee are served in their facility. [Supplemental #1, Page 4] The specifics of where in "Northeast Tennessee" these patients are located and, therefore, the distance they travel to Asheville, NC or Knoxville, TN is not provided by the Applicant, except that it is noted that the Knoxville, TN clinic is 104 miles from the proposed project location. Other data was submitted showing travel distances from Johnson City, Kingsport, and Bristol to Asheville, NC and Knoxville, TN; but the 1,000 patients reported to be receiving treatment in either the Asheville, NC or Knoxville, TN clinic have only been identified as being from "Northeast Tennessee", not these cities in particular, so it is not clear if the proposed project would improve driving distances for the reported existing patients. When discussing need in terms of where prescription pain medication abuse is the highest, the Applicant reports that the abuse of prescription pain medication is an epidemic in the United States and that the rate of abuse is higher in the proposed service area; however, as discussed in more detail in Section C.1., the study cited for this statement includes "Overall Conclusions" beginning on Page 226 of the study that report that "admission rates for the primary abuse of other opiates and synthetics [including hydrocodone, oxycodone, and any other drug with morphine-like effects except methadone] are higher in Appalachia than in the rest of the nation" [and] "in many ways, access to treatment is better in Appalachia when compared to the rest of the nation." The Applicant reports that there are "no existing SAMHSA-designated methadone maintenance treatment programs in [the] proposed service area"; therefore, there is a need. [Supplemental #1, Page 4] While it is true that there are no methadone clinics in the proposed service area, it is not true that there isn't access to medication assisted therapy and other forms of treatment in the proposed service area for those suffering from opioid addiction, as demonstrated in the list of providers submitted with the application. [Supplemental #1, Pages 99-103]

3. Economic Feasibility has possibly been established as described in further detail in Section C.2. The overall cost of the proposed project appears to be reasonable and, if the application is approved and all other requirements are met, the project should be able to be completed in a timely manner. The Applicant reports that the project will be funded personally by Mr. Steven W. Kester, identified as the "Managing Member of Applicant". It is reported that the monies are in reserve and have been committed to more than cover the project costs and start-up operating loss(es). In a March 15, 2013 letter from the Health Services and Development Agency (HSDA) to Applicant, Applicant is requested to submit a letter from a banking institution, Certified Public Accountant, etc. that demonstrates financial resources and/or reserves to implement the proposed project. In Supplemental #2 information, there is a facsimile from the Maxim Group indicating brokerage account balances of Mr. Steven W. Kester as of March 27, 2013. In a later letter from the HSDA to Applicant, the facsimile is noted, but there is another request for a letter from a banking institution, Certified Public Accountant, etc. that demonstrates financial resources and/or reserves to implement the proposed project. Staff of the TDMHSAS reviewing the application cannot find the requested documentation, but do take note of the statements in the application that the Applicant's Manager has sufficient resources in a brokerage account under his control for purposes of financially securing this project and that "all funds required to open and outfit this facility, and cover the operating loss during the first year, plus contingency, are secured." [Supplemental #1, Page 40] A review of the proposed charges for methadone at the facility causes concern to TDMHSAS licensure staff as discussed in Section C.2.
4. The project does not contribute to the orderly development of healthcare as described in further detail in Section C.3. The application under review is for a new facility. The Applicant, Tri-Cities Holdings, LLC d/b/a Trex Treatment Center, was organized pursuant to the Georgia Limited Liability Company Act on January 15, 2013 and was established to "engage solely for the formation of an opiate treatment program in the 'Tri-Cities' region of Tennessee and Virginia" [Supplemental #1, Page 75] Therefore, the Applicant has no prior experience in the operation of this type of facility or program other than the leadership and experience of its Manager who has "successfully opened nine (9) such facilities in four (4) states in five (5) years." [Supplemental #1, Page 5] When discussing transfer agreements, contractual agreements for health services, and affiliation of the project with health professional schools, since this is a new project, there are no existing agreements and affiliations, but the Applicant reports that it intends to have transfer relationships with all emergency hospitals in the Tri-Cities and surrounding area. Applicant also reports significant experience developing internships and other partnerships with local universities and professional societies, and looks forward to establishing these in the proposed service area. [Supplemental #1, Pages 42 and 44] As of the writing of this report, there are no letters of support from any of these entities in the proposed service area. When discussing staffing and the availability and accessibility of human resources required for the project, Applicant reports that it

recognizes the challenge of hiring and keeping the right staff and reports that all personnel will satisfy the TDMHSAS licensure rules, however, the staffing chart provided on Supplemental #1, Page 43 does not contain enough information to determine, at this time, if the staffing requirements will be met. For the criteria requesting documentation of deficiencies, if any, for existing licensed providers, and when the Applicant was requested to provide health survey results for the centers in North Carolina for which the Applicant's Manager claims "co-founder" and "part-owner" status, the response was that Applicant is a "shareholder of the company that operates these centers, but is not an officer or member of management ... [so] has no access to these records." [Supplemental #1, Page 45] Applicant verifies that it has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Substance Abuse Services, and/or any applicable Medicare requirements. In information provided in Supplemental #2 [Page 4 of a March 27, 2013 letter], Applicant also reports that TDMHSAS staff explained the licensing and Central Registry procedures for this type of program, however, the response to whether the Applicant will provide the HSDA and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required, the Applicant responded "Yes, subject to Federal HIPAA regulation." [Supplemental #1, Page 45] It is unclear whether Applicant is fully aware of and understands the complexity of all federal, Tennessee, and local laws, regulations, rules, and ordinances governing the establishment and operation of this type of facility and program. When asked about alternatives, the Applicant reported that more than fifty (50) locations in the Tri-Cities area were reviewed before selecting the proposed site of 4 Wesley Court. Further, the Applicant reported that the proposed site best meets the zoning requirements and was chosen because it is located in the biggest city of the proposed service area; is close to the maximum number of anticipated patients; has ready highway access to all points within the proposed service area; and requires only modifications to an existing structure, no new construction. [Supplemental #1, Page 41] The Applicant reports that it has "balanced cost control with providing patients quality care and a healing environment." [Supplemental #1, Page 41] In the March 15, 2013 letter from HSDA to Applicant, the Applicant was requested to provide a current letter from the City of Johnson City that the proposed site meets zoning requirements. Staff of the TDMHSAS reviewing the application cannot find the requested documentation, but do take note of statements in the application that the Applicant has requested zoning variances to accommodate this project. See Section C.3. for further discussion about zoning.

C. ANALYSIS

1. Need

Tri-Cities Holdings, LLC d/b/a/ Trex Treatment Center (Applicant) is seeking the establishment of a new "outpatient opiate treatment program (OTP)" to be located at 4

Wesley Court in Johnson City, Washington County, Tennessee. An "outpatient opiate treatment program" is also referred to as a "Non-Residential Substitution-Based Treatment Center for Opiate Addiction"; "Opioid Treatment Program" (OTP); or "methadone clinic").

Overall, need has not been clearly established. The Applicant takes national projections and applies them to Tennessee and specifically Upper Northeast, Tennessee resulting in a misrepresentation of need. Many of the conclusions and inferences drawn by the Applicant from cited references are not scientifically based and national studies and statistics are mis-applied to the Upper Northeast, Tennessee area.

When asked to provide the estimated number of persons, in the described area, addicted to heroin or other opioid drugs and an explanation of the basis for the estimate, the Applicant reports that there are approximately between 12,000 and 24,000 adults who are addicted to opiates in the proposed service area. The Applicant derived these from the following: the Substance Abuse and Mental Health Services Administration (SAMHSA) reports that "heroin use was 0.3% in 2011 and prescription pain medication abuse was 1.7% [therefore] combined, this would yield 12,000 opiate abusers or opiate dependents from the proposed service area." [Supplemental #1, Page 19] Further, the Applicant reports that the Tennessee Safety Subcabinet Working Group report [*Prescription Drug Abuse in Tennessee*] indicates that "almost 250,000 Tennesseans older than 12 reported abusing prescription opioids in 2009; Tennessee's population was approximately 6.3 million in 2009, yielding an incidence rate of 3.9%; this alone would yield approximately 23,800 opiate abusers or opiate dependents from the proposed service area." [Supplemental #1, Page 14] It is not clear how the Applicant arrived at its numbers. Further, the Applicant reports that an estimated number of 950 and 1,500 individuals from the proposed service area are in methadone treatment, relying on data from the methadone clinics in the Asheville, NC area, Knoxville, TN, and Boone, NC. [Supplemental #1, Pages 19-20] Due to a change in federal regulations, current Tennessee Methadone Central Registry data is not available. However, Applicant did provide calendar year 2008 data from the Tennessee Methadone Central Registry. [Supplemental #1, Pages 110B-110G] The Applicant incorrectly calculated that this data shows 8,889 Tennessee individuals receiving services at Tennessee methadone clinics. The Applicant did not deduct the number of individuals reported with a "county of residence" of 'unknown', nor did the Applicant deduct the number of individuals reported with a "county of residence" of 'out of state'. Using Applicant's figures of 8,889 and a state population at the time (2008) of 6,156,719, Applicant reports that there would be 866 patients in the proposed service area. [Supplemental #1, Page 19] Looking at the calendar year 2008 data and adding up the number of individuals with a "county of residence" of each of the nine (9) counties in the proposed service area, there are a total of 150 individuals from all nine (9) counties of the proposed service area, combined, reported to be receiving methadone treatment at the Knoxville, TN clinics. As mentioned, current data from the Tennessee Methadone Central Registry is not available, but it is not believed that there has been what amounts to a 2.5 times increase in the number of people from the counties in the proposed service area receiving services from a methadone clinic, which

is what would be needed to arrive at the Applicant's reported number of "nearly 400" patients receiving treatment at the Knoxville, TN clinic.

Need is also evaluated by the factors of special needs of the service area population, particularly women, racial and ethnic minorities, and low-income groups as well as the extent to which Medicare, Medicaid, and medically indigent patients will be served. Participation in Medicare and Medicaid is discussed in Section C.3. The Applicant states that a CDC report "clearly shows that opioid abuse and overdose cuts across genders, age groups, race, metropolitan status and economics [and] shows that Tennessee is among the 12 states with the highest per-capita overdose rates in the nation." [Supplemental #2, Page 22] A review of the cited reference [<http://www.fda.gov/downloads/Drugs/NewsEvents/UCM300859.pdf>] cannot confirm the Applicant's statements; the author of the cited reference states that "the findings and conclusions in this report are those of the author and do not represent the official position of the Centers for Disease Control and Prevention." Furthermore, states that are specifically covered in the presentation include Ohio, Utah, North Carolina, West Virginia, and New Mexico, not Tennessee.

The Applicant reports that the proposed service area is the nine (9) most northeastern counties of Tennessee: Sullivan, Washington, Greene, Hamblen, Carter, Hawkins, Cocke, Unicoi, and Johnson, which reportedly covers 100% of the population of Tennessee's Methadone Service Area (MSA) #1, 97% of MSA #2, and 70% of MSA #3. Applicant further reports that the MSAs were specifically addressed to balance population with proximity to care and notes that "[b]asically, where the State said there should be three facilities in 2002, there are none today, and the need has become materially more pronounced since that time." The Applicant does not cite a reference in support of this particular statement. [Supplemental #2, Page 22] A map of the MSAs was included with the application [Attachment C.3., Supplemental #1, Page 119], and while there are some pages that identify which counties are included in which MSA [Supplemental #1, Pages 120-121], there is nothing else to use to verify the Applicant's statement regarding the number of facilities expected to be located in each MSA.

Additional information provided in Supplemental #2 gives more detail about MSAs. It is noted that Tennessee Public Chapter 363 of the Acts of the 2001 General Assembly created Methadone Service Areas (MSAs) on the assumption that the closer one lives to a treatment program, the greater likelihood of participation. It is noted that the rate of participation is nearly twice as high for those living in or near a county that houses a methadone program (59.0/100,000) than the rate for those that live sixty (60) miles or more from a program (32.2/100,000). [Supplemental #2, Page 3 of the March 27, 2013 letter] Noted in the Tennessee Department of Health's report prepared as a response to Public Chapter 363 of the Acts of the 2001 General Assembly [<http://health.state.tn.us/Downloads/g6022004.pdf>], the State of Tennessee had a proposal to designate twenty-three (23) MSAs within the state to assure that all Tennesseans who wished to participate in a methadone maintenance treatment (MMT) program would have reasonable access to a program. An MSA, patterned in concept after the use of Rational Service Areas by the Department of Health in helping identify underserved health resource shortage areas in the state, is described as a "county or

constellation of contiguous counties in the state that comprise a sufficient general population making it likely that a minimum number of opiate dependent persons reside in the MSA who wish treatment and could support a program. This minimum population foundation was balanced with the need to establish geographic boundaries such that patients living within the MSA would reside within less than an hour drive one-way to a treatment program if the program were established in the heart of the MSA." [Page 8 of the report/response] The Applicant reports that it is estimated that 90% of the proposed service area's population is within sixty (60) miles of the proposed project location. [Supplemental #2, Page 3 of the March 27, 2013 letter] However, since the 1,000 patients reported by Applicant to be receiving treatment in either the Asheville, NC or Knoxville, TN clinic have only been identified as being from "Northeast Tennessee", it is not clear that Applicant's statements and conclusions support a need for the proposed project.

One of the other facts noted in the Department of Health's report/response is that businesses that establish programs require a general population of at least 100,000 persons from which to draw potential clients, generating 67 clients on average. [Page 6 of the report/response] The Applicant reports that six hundred (600) patients from Northeast Tennessee travel to the Asheville, NC facilities for services, and an admissions counselor at the Knoxville, TN facility (owned by the Behavioral Health Group) indicated, in a phone call placed by the Applicant's Manager on February 25, 2013, that "nearly four hundred (400)" patients from Northeast Tennessee are served in their facility. [Supplemental #1, Page 4] The specifics of where in "Northeast Tennessee" these patients are located have not been provided.

In other information provided by the Applicant describing the relationship of the proposed site to public transportation routes and general accessibility of the proposed site to potential patients, the Applicant reports that the proposed site is less than a quarter of a mile to transit stops on Johnson City's Transit System Blue Route and that the proposed location is less than one mile to I-26; a 20-minute drive from Kingsport, and a 22 mile drive from Bristol. The Applicant submitted a chart that shows it is 45 miles from Johnson City, TN to Weaverville, NC; 104 miles from Johnson City, TN to Knoxville, TN; and would be 0 miles from Johnson City to the proposed project location representing a "major improvement of the driving distances patients currently go for treatment". [Supplemental #1, Page 14] Similar data was submitted for patients living in Kingsport and Bristol; however, the 1,000 patients reported to be receiving treatment in either the Asheville, NC or Knoxville, TN clinic have only been identified as being from "Northeast Tennessee", not these particular cities. Elsewhere in the application, when discussing need in terms of barriers to treatment, particularly the distance to treatment, the Applicant reports that "of the barriers to access to healthcare, geographic distance is [at] the top of the list, even higher than access to healthcare insurance." [Supplement #1, Page 5] The TDMHSAS staff reviewing the application cannot verify this statement due to the cited reference being incomplete. The Applicant points out that a Johnson City, TN patient travels 200 miles round trip to Knoxville, TN and consumes approximately \$30.00 in gas and over three (3) hours of drive time, which is a hardship for patients, especially new patients who need to receive treatment seven (7) days per week. The Applicant further reports that "for every patient that makes the

commute, several are most likely foregoing treatment because they can't afford the time, money or energy." [Supplement #1, Page 5] It is interesting to note that the calendar year 2008 Tennessee Methadone Central Registry data shows only six (6) patients with a "county of residence" of 'Washington' receiving services at the Knoxville, TN clinics. The Applicant has not specifically identified any patients as being "Johnson City patients", but has only identified the 1,000 patients reported to be receiving treatment in either the Asheville, NC or Knoxville, TN clinic as being from "Northeast Tennessee"; therefore, it is not clear that Applicant's statement and conclusions support a need for the proposed project.

When discussing need in terms of where prescription pain medication abuse is the highest, the Applicant reports that the abuse of prescription pain medication is an epidemic in the United States and that the rate of abuse is higher in the proposed service area. However, the study cited by the Applicant for this statement [<http://www.kentucky.com/static/pdfs/ARCReport.pdf>] is from a May 2008 report by members of the National Opinion Research Center (NORC) at the University of Chicago and two members of East Tennessee State University presented to the Appalachian Regional Commission and is an analysis of disparities in mental health status and substance abuse prevalence, as well as access to treatment services in the entire 410 county Appalachian region comprising all or parts of thirteen (13) states, specifically all of West Virginia and parts of these twelve (12) states: Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, and Virginia. As noted in the study, the Appalachian region is home to more than 23 million people, extending from southern New York to northeast Mississippi and covers over 200,000 square miles of 410 counties in 13 states. The study does not specifically mention how many methadone clinics are in the Appalachian region, however, there are tables in the study that show that in 2005 there were a total of 891 substance abuse treatment facilities in the region with 16.59% of them providing Naltrexone; 8.24% of them providing methadone; 8.15% of them providing buprenorphine-Suboxone; and 5.10% of them providing Buprenorphine-Subutex (Pages 157-160). The study does not contain specifics on the locations of any of these facilities, so it is not clear that the results of this study can be appropriately applied to the proposed service area. It is interesting to note that in the "Overall Conclusions" statements of this study, beginning on Page 226, it is mentioned that "admission rates for the primary abuse of other opiates and synthetics [including hydrocodone, oxycodone, and any other drug with morphine-like effects except methadone] are higher in Appalachia than in the rest of the nation" [and] "in many ways, access to treatment is better in Appalachia when compared to the rest of the nation."

Last, but not least, when discussing the relationship of the proposed project to existing treatment in the proposed service area, the Applicant reports that there are "no existing SAMHSA-designated methadone maintenance treatment programs in [the] proposed service area"; therefore, there is a need. [Supplemental #1, Page 4] As stated previously, the Applicant takes national projections and applies them to Tennessee and specifically Upper Northeast, Tennessee resulting in a misrepresentation of need. Furthermore, many of the conclusions and inferences drawn by the Applicant from

cited references are not scientifically based and national studies and statistics are misapplied to the Upper Northeast, Tennessee area. While it is true that there are no methadone clinics in the proposed service area, it is not true that there isn't access to medication assisted therapy and other forms of treatment in the proposed service area for those suffering from opioid addiction, as demonstrated in the list of providers submitted with the application. [Supplemental #1, Pages 99-103]

2. Economic Feasibility

A review of the information supplied by the Applicant shows that there should be sufficient funds available for this project. The Applicant reports that the project will be funded personally by Mr. Steven W. Kester, identified as the "Managing Member of Applicant". It is reported that the monies are in reserve and have been committed to more than cover the project costs and start-up operating loss(es). In a March 15, 2013 letter from the Health Services and Development Agency (HSDA) to Applicant, Applicant is requested to submit a letter from a banking institution, Certified Public Accountant, etc. that demonstrates financial resources and/or reserves to implement the proposed project. In Supplemental #2 information, there is a facsimile from the Maxim Group indicating brokerage account balances of Mr. Steven W. Kester as of March 27, 2013. In a later letter from the HSDA to Applicant, the facsimile is noted, but there is another request for a letter from a banking institution, Certified Public Accountant, etc. that demonstrates financial resources and/or reserves to implement the proposed project. Staff of the TDMHSAS reviewing the application cannot find the requested documentation, but do take note of the statements in the application that the Applicant's Manager has sufficient resources in a brokerage account under his control for purposes of financially securing this project and that "all funds required to open and outfit this facility, and cover the operating loss during the first year, plus contingency, are secured." [Supplemental #1, Page 40]

This application under review is for the establishment of a new facility to be operated as a non-residential methadone facility [Item 7.N. in the Applicant Profile] Such a facility is also referred to as an "outpatient opiate treatment program"; a "Non-Residential Substitution-Based Treatment Center for Opiate Addiction"; "Opioid Treatment Program" (OTP); or "methadone clinic". The Applicant, Tri-Cities Holdings, LLC d/b/a Trex Treatment Center, was organized pursuant to the Georgia Limited Liability Company Act on January 15, 2013 and was established to "engage solely for the formation of an opiate treatment program in the 'Tri-Cities' region of Tennessee and Virginia" [Supplemental #1, Page 75] Therefore, the Applicant has no prior experience in the operation of this type of program other than the leadership and experience of its Manager who has "successfully opened nine (9) such facilities in four (4) states in five (5) years." [Supplemental #1, Page 5] Information provided in the application [Supplemental #1, Page 4] names seven (7) facilities: two (2) in the Asheville area (Crossroads Treatment Centers of Weaverville, NC and Asheville); three (3) more in Asheville (Western Carolina, CRC, and Mountain Area Recovery Center); and two (2) in Boone, NC (Stepping Stone and McLeod).

The Applicant reports that the total estimated project cost is \$670,000.00 which includes \$320,000.00 for facility costs [lease at an average of \$5,333.00 per month]; \$160,000.00 for preparation of site costs; \$80,000.00 for "operating loss carry" which was explained as the amount that needs to be financed during the time between when the facility opens until it becomes cashflow positive; and \$30,000.00 for legal, administrative, and consultant fees which the Applicant reported includes accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF). Applicant reports that the costs were developed with the Applicant's experience of having opened nine (9) such facilities in four (4) states and are "standard work elements" such as wall construction and moving walls; adding electrical, phones, cable and security; reconfiguring heating and air conditioning systems; adding workrooms unique to this type of facility (dosing windows, pharmacy, payment area, check-in area); outfitting the offices with desks, computers, and phones; and installing patient and accounting software systems unique to this type of facility. [Supplemental #1, Page 33] When asked to provide data for the Historical Data Chart for Net Operating Revenue, Net Operating Income (Loss), and other such information, for the last three (3) years for a center in Asheville, NC for which Applicant claims ownership, Applicant responded that as a shareholder of the company, not an officer or member of management, there is no access to this information. [Supplemental #1, Page 34]

The Applicant reports that there is no major medical equipment involved in the project other than the dispensing devices used to correctly administer medication doses. The Applicant reports that the proposed building on the proposed site (at 4 Wesley Court) expected to be used for the facility requires no structural modifications, but will be renovated as follows: the lobby will be re-purposed as a waiting room; large rooms will be partitioned to create offices for counselors, doctors, and the Executive Director; other large rooms will be partitioned and have plumbing added for use as examination and lab rooms; dosing rooms and associated dosing windows will be constructed; a room for the pharmacy and associated medicine vault will be constructed; a check-in booth will be constructed; and electrical, cabling, video, and telephony will be added in/for all rooms. [Supplemental #1, Page 6]

The Applicant reports that the proposed location is 4 Wesley Court, Johnson City, Washington County, Tennessee. The existing building is a free-standing building in what Applicant calls an industrial area, zoned for medical services, approximately 0.2 miles from the Quillen Rehabilitation Hospital. The Applicant acknowledges that Johnson City has "strict zoning requirements regarding locations of [methadone clinics]" [Supplemental #1, Page 10], but also reports that it spent significant time finding a location that best meets the zoning requirements and is well outside all limits that the city has imposed regarding schools, daycare facilities, parks, or locations that sell alcoholic beverages, as shown on a chart supplied with the application. [Supplemental #1, Page 12] It is important to note that the Zoning Code for Johnson City does permit "clinics" within the MS-1 Medical Services District [6.13.2.7], but defines a "clinic" as follows: "A building or portion of a building, other than a hospital, as herein defined, containing facilities providing outpatient medical, dental, chiropractic, optical, osteopathic diagnostic, and similar services, for humans, by physicians, dentists, and other health care specialists. The term clinic includes offices as a separate use for the

above, but does not include Substance Abuse Treatment Facility, or Methadone Treatment Clinic." [City of Johnson City Zoning Code] See Section C.3. for more discussion about zoning.

The proposed location is 1.66 acres and the square footage of the building is 8,260 square feet. Applicant reports that the facility has parking on all four (4) sides of the building, plus on an adjacent side lot and street parking is permitted. Applicant reports that the capacity of parking is sufficient to accommodate patients and, when asked to clarify if the space for the additional parking spaces is already owned by Applicant, the Applicant provided a chart showing the ratio of parking spaces to patients at the proposed facility in comparison to other similar facilities and reported that it is not believed that parking is an issue and no costs were reflected in the Projected Data Chart to remedy a parking problem. [Supplemental #2, Page 5] The proposed site is located on a cul-de-sac with industrial and commercial customers as neighbors. See Section C.3. for discussion on zoning with respect to being located on a cul-de-sac. The Applicant reports that traffic on the street is very light given the limited number [of businesses], hours of operations, and nature of the businesses. [Supplemental #1, Page 10]

The Applicant submitted a line-drawn floor plan showing the location of "counseling" rooms; "storage"; "break room"; "dosing rooms"; "exam room"; "pharmacy" [including vault]; the "check-in/payment" area; the "lobby/reception" area; and a "Group Room". The space marked "pharmacy" raises the question of whether the facility intends to have a pharmacy or if this room has been mis-labeled and is the 'medroom'. If the facility is to have a pharmacy, the Applicant must meet the requirements of the Tennessee Board of Pharmacy. There is also space marked for a "Director", but it is not clear if it is for the Program Director or the Medical Director. [Supplemental #1, Page 15] When asked about seating, Applicant reports that the lobby area could accommodate 153 seats and overflow seating, should it be needed, would be in the common area shown on the diagram.

On the Projected Data Chart [Supplemental #2a, Pages 30 and 31], the Applicant reports gross operating revenue from outpatient services, to an average of 530 patients in the first year of operation (expected to be 2014), of \$1,782,144.00. For the second year of operation (expected to be 2015), for services to an average of 1,056 patients, gross operating revenue is reported as \$3,903,715.00. Also reported are amounts for charity care of \$35,643.00 (Year 1) and \$78,074.00 (Year 2). Also reported are amounts for bad debt of \$17,821.00 (Year 1) and \$39,037.00 (Year 2). The resulting Net Operating Revenue is reported as \$1,728,680.00 (Year 1) and \$3,786,604.00 (Year 2). The chart shows deductions for operating expenses, other expenses, and capital expenditures of \$1,721,042.00 (Year 1) and \$3,221,026.00 (Year 2), resulting in a projected Net Operating Income of \$7,638.00 (Year 1) and \$565,578.00 (Year 2).

As previously stated, when asked to provide data for the Historical Data Chart for Net Operating Revenue, Net Operating Income (Loss), and other such information, for the last three (3) years for a center in Asheville, NC for which Applicant claims ownership, Applicant responded that as a shareholder of the company, not an officer or member of

management, there is no access to this information. [Supplemental #1, Page 34] Without this information, it cannot be determined if the reported projected numbers are in line with data from any of the other seven (7) facilities named in the application.

On Supplemental #1, Page 37, the Applicant reports a proposed charge of \$10.00 per day (\$70.00 per week) for methadone maintenance treatment at the proposed facility. The Applicant provided a comparison chart [Supplemental #1, Page 38] that shows charges at the proposed facility and those at some of the other facilities named in the application. The Applicant reports that since this is a new project there is no impact to previous charge schedules. The Applicant further reports that the proposed charge is 20%-33% less than charges at the nearest clinics in North Carolina and Tennessee. When asked for a further explanation, Applicant reports "tremendous benefit to lowering the barriers to treatment, and cost is a major factor; Applicant's Manager's other clinics in which he owns a partial interest, [have] tremendous results 'getting the word out' and breaking down barrier to treatment by offering treatment for \$1 per day for periods of six months to over a year." [Supplemental #2, Page 7] Elsewhere in the application, it is reported that the Applicant has reviewed and understands the licensure requirements of the TDMHSAS for this type of facility, however, the charge scheme proposed by the Applicant would be prohibited by the TDMHSAS licensure rules.

When asked about participation in Medicare and/or Medicaid, the Applicant responded that the project will not involve the treatment of TennCare participants and that certification will not be sought for Medicare and/or Medicaid. [Applicant Profile, Items 12 and 13, Supplemental #1, Page 3] Further, the Applicant reported that it plans to utilize self-pay programs and does not plan to participate in State and federal programs such as TennCare or Medicare because it "cannot justify the investment of resources required to maintain compliance with TennCare." [Supplemental #1, Page 40] Applicant did note, however, that a call to TennCare Solutions revealed that TennCare patients can be reimbursed for approved medication and services upon individual submission of receipts. When asked for further clarification, Applicant submitted additional information in Supplemental #2 and stated "Applicant will not offer any warranty or representation about TennCare coverage as to any item of service or medication [and] does not intend to make claims on behalf of any patient to TennCare." [Supplemental #2, Pages 2 and 3 of the March 27, 2013 letter] In the March 27, 2013 letter from HSDA to Applicant, it was mentioned that TennCare covers the drug buprenorphine for treatment of opiate addiction and that the medication, medical services, and transportation to providers are covered TennCare benefits. The Applicant was asked to clarify why it is not planning to accept TennCare for suboxone patients. Applicant responded that "the investment in personnel and systems, the on-going compliance and audit requirements, and the risk of penalties for non-compliance do not warrant the added revenue." [Supplemental #2, Page 1 of the March 27, 2013 letter] Further, the Applicant states that based on its experience, there are "additional risks associated with comingling TennCare patients with self-pay patients [such as] arguments, humiliation, etc. such that [it] is not worth implementing TennCare." [Supplemental #2, Page 1 of the March 27, 2013 letter]

When asked about availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal, the Applicant reported that there is "no treatment in the proposed service area [and that the proposal may appear to be more expensive than the status quo of no service, but] many organizations have documented [that] the cost of untreated persons significantly outweigh the cost of treatment, ..." [Supplemental #1, Page 40] The cited reference is the website of the TDMHSAS, but no particular document, article, or other source of this statement has been provided; therefore, the statement cannot be verified.

As for other alternatives regarding location and/or construction, the Applicant reported that more than fifty (50) locations in the Tri-Cities area were reviewed before selecting the proposed site of 4 Wesley Court. Further, the Applicant reported that the proposed site best meets the zoning requirements and was chosen because it is located in the biggest city of the proposed service area; is close to the maximum number of anticipated patients; has ready highway access to all points within the proposed service area; and requires only modifications to an existing structure, no new construction. [Supplemental #1, Page 41] See Section C.3. for discussion about zoning.

3. Contribution to the Orderly Development of Health Care

As stated elsewhere, the application under review is for a new facility. The Applicant, Tri-Cities Holdings, LLC d/b/a Trex Treatment Center, was organized pursuant to the Georgia Limited Liability Company Act on January 15, 2013 and was established to "engage solely for the formation of an opiate treatment program in the 'Tri-Cities' region of Tennessee and Virginia" [Supplemental #1, Page 75] Therefore, the Applicant has no prior experience in the operation of this type of facility or program other than the leadership and experience of its Manager who has "successfully opened nine (9) such facilities in four (4) states in five (5) years." [Supplemental #1, Page 5] When discussing transfer agreements, contractual agreements for health services, and affiliation of the project with health professional schools, since this is a new project, there are no existing agreements and affiliations, but the Applicant reports that it intends to have transfer relationships with all emergency hospitals in the Tri-Cities and surrounding area, including the Johnson City Medical Center and Wellmont Urgent Care (in Johnson City); Holston Valley Medical Center and Indian Path Primary Care (both in Kingsport); Bristol Regional; Union County Memorial (Erwin); Laughlin Memorial (Greeneville); and Hawkins County Memorial (Rogersville). Applicant also reports significant experience developing internships and other partnerships with local universities and professional societies, and looks forward to establishing these with East Tennessee State University's (ETSU's) undergraduate and graduate healthcare programs and Northeast State Community College's Social Work program. [Supplemental #1, Pages 42 and 44] As of the writing of this report, there are no letters of support or opposition from any of these entities; however, the documentation from the 2002 application for a proposed methadone clinic in Johnson City contains a letter of opposition from the then Dean of Medicine and Vice President for Health Affairs at the James H. Quillen College of Medicine at ETSU. The letter indicates that they did not participate in the "development of [the] proposal and do not support the opening of such a clinic in Johnson City." It is not known whether ETSU's position has changed.

When discussing staffing and the availability and accessibility of human resources required for the project, Applicant reports that it recognizes the challenge of hiring and

keeping the right staff and is "experienced and financed ready to meet the challenges." [Supplemental #1, Page 44] Further, Applicant verifies that it has reviewed and understands all licensing certification as required by the State of Tennessee for medical and clinical staff. When asked to clarify if a Program Director or Medical Director has been identified and to provide their names and background, Applicant responded that candidates have been interviewed and meet certification requirements, but due to the "uncertainty with respect to approval and timing, offers cannot be extended and candidates do not wish to be identified." [Supplemental #1, Page 43] When asked to clarify whether the Substance Abuse Counselors will be certified, the Applicant reports that all personnel will satisfy the State Minimum Program Requirements for Non-Residential Opioid Treatment Program Facilities, Staff Qualifications [Personnel and Staffing Requirements], Rule 0940-05-42-.29 [Supplemental #1, Page 43], however, the staffing chart provided on Supplemental #1, Page 43 does not contain enough information to determine, at this time, if the staffing requirements will be met and if staff will have the appropriate certifications. For instance, there is no mention of Physician Assistants or Advance Practice Nurses, no mention of a Program Physician, and no mention of which personnel will serve as Community Relations Coordinators. Applicant reports that a Security Guard is not planned, but if the need arises, a Security Guard will be hired. [Supplemental #1, Page 43]

For the criteria requesting documentation of deficiencies, if any, for existing licensed providers, the response is "not applicable". [Supplemental #1, Page 45] When requested to provide health survey results for the centers in North Carolina for which the Applicant's Manager claims "co-founder" and "part-owner" status, the response was that Applicant is a "shareholder of the company that operates these centers, but is not an officer or member of management ... [so] has no access to these records." [Supplemental #1, Page 45]

When discussing the understanding of standards and requirements, Applicant verifies that it has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Substance Abuse Services, and/or any applicable Medicare requirements. In information provided in Supplemental #2 [Page 4 of a March 27, 2013 letter], Applicant also reports that TDMHSAS staff explained the licensing and Central Registry procedures for this type of program, however, the response to whether the Applicant will provide the HSDA and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required, the Applicant responded "Yes, subject to Federal HIPAA regulation." [Supplemental #1, Page 45] It is unclear whether Applicant is fully aware of and understands the complexity of all federal, Tennessee, and local laws, regulations, rules, and ordinances governing the establishment and operation of this type of facility and program. It should be noted that the requirement to provide data for a Methadone Central Registry is a federal regulation and is also required by the TDMHSAS licensure rules, but has nothing to do with the HIPAA regulations.

When asked about alternatives, the Applicant reported that more than fifty (50) locations in the Tri-Cities area were reviewed before selecting the proposed site of 4 Wesley Court. Further, the Applicant reported that the proposed site best meets the zoning requirements and was chosen because it is located in the biggest city of the

proposed service area; is close to the maximum number of anticipated patients; has ready highway access to all points within the proposed service area; and requires only modifications to an existing structure, no new construction. [Supplemental #1, Page 41] The Applicant reports that it has "balanced cost control with providing patients quality care and a healing environment." [Supplemental #1, Page 41] As mentioned elsewhere, the proposed site is located on a cul-de-sac with industrial and commercial customers as neighbors. See Section C.3. for discussion on zoning with respect to being located on a cul-de-sac. The Applicant reports that traffic on the street is very light given the limited number [of businesses], hours of operations, and nature of the businesses. [Supplemental #1, Page 10] The Applicant was asked to provide, if possible, letters of support from the businesses that are located in the immediate area of the proposed location. Information provided in Supplemental #2 indicates that the other two (2) businesses located on Wesley Court are related to construction and the Applicant contacted the landlord/owner of one of the businesses and the individual "voiced no opposition" and the landlord of the Applicant's proposed site "knows the owner/landlord of the other business and has briefed that individual, and this individual has voice[d] no opposition to date. The Applicant would characterize their responses as neutral." [Supplemental #2, Page 4 of the March 27, 2013 letter]

As for the zoning requirements, in the March 15, 2013 letter from HSDA to Applicant, the Applicant was requested to provide a current letter from the City of Johnson City that the proposed site meets zoning requirements. Staff of the TDMHSAS reviewing the application cannot find the requested documentation, but do take note of statements in the application that the Applicant has requested zoning variances to accommodate this project. In Supplemental information, as requested, the Applicant provided a copy of the City of Johnson City zoning requirements [Supplemental #1, Pages 106-109]. As these zoning requirements show, the Board of Zoning Appeals is permitted to approve such a facility as a "special exception" only if the proposed facility complies with all five (5) criteria contained in Section 6.13.3.4 A.-F. As noted in other supplemental information, the proposed site for the facility is on a cul-de-sac, not an arterial street; therefore, does not comply with required criteria. Further, the proposed hours of operation are other than that required in the criteria. In Supplemental #2 information, the Applicant, when asked how it intends to address the zoning regulations, particularly the cul-de-sac versus arterial street and the proposed hours of operation, the response is that Applicant has requested a zoning variance from Johnson City. [Supplemental #2, Page 4] It should be noted that the Board of Zoning Appeals has no authority to grant a variance to special exceptions set forth in a Zoning Code, their role is to ascertain whether all criteria of a special exception have been met or not.

sbj
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LETTER OF INTENT

TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Johnson City Press which is a newspaper of general circulation in Washington, Tennessee, on or before March 7, 2013 for one day.

(County) (Name of Newspaper) (Month / day) (Year)

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency,

Tri-Cities Holdings LLC d/b/a Trex Treatment Center

NA

(Name of Applicant)

(Facility Type-Existing)

owned by: Tri-Cities Holdings LLC with an ownership type of Limited Liability Company

and to be managed by: Manager Steve Kester intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]:

Establishment of a nonresidential substitution-based treatment center for opiate addiction offering methadone and buprenorphine which is designed to treat opiate addiction by preventing symptoms of withdrawal. In addition, we will offer individual counseling services and group therapy to help break the cycle of addiction and provide patients the life skills and resources to serve as productive members of their communities, families and employers.. The location of the proposed project is 5 Wesley Court, Johnson City, Tennessee 37601. The project cost is estimated to be \$670,000.

The anticipated date of filing the application is: March 7, 2013

The contact person for this project is Steve Kester Manager

(Contact Name) (Title)

who may be reached at: Tri-Cities Holdings LLC 6555 Sugarloaf Parkway Suite 307-137

(Company Name) (Address)

Duluth Georgia 30097 404-664-2616

(City) (State) (Zip Code) (Area Code / Phone Number)

SWK March 1, 2013 swkester@gmail.com

(Signature) (Date) (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
The Frost Building, Third Floor
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.



STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
161 Rosa L. Parks Boulevard
3rd Floor
Nashville, TN 37243
615/741-2364

May 8, 2013

Steven W. Kester
Tri Cities Holdings LLC
6555 Sugarloaf Parkway, Suite 307-137
Duluth, GA 30097

RE: Certificate of Need Application: CN1303-005, Tri-Cities Holding LLC d/b/a Trex Treatment Center – Establishment of a non-residential substitution-based treatment center for opiate addiction.

Dear Mr. Kester:

In accordance with Tennessee Code Annotated, §68-11-1608(b), The Tennessee Health Services and Development Agency will conduct a fact-finding public hearing on May 28, 2013 at 5:00 p.m., eastern daylight time, in the Jones Meeting Center, Johnson City Public Library, 100 W. Millard Street, Johnson City, Tennessee, 37604, to consider the following Certificate of Need Application:

Tri-Cities Holdings, LLC d/b/a Trex Treatment Center, CN1303-005. This application proposes the initiation of opiate addiction treatment through the establishment of a non-residential substitution-based treatment center for opiate addiction at 4 Wesley Court, Johnson City (Washington County), TN 37601.

You will be allotted ten (10) minutes to summarize and present the merits of the application at the public hearing; however your decision to attend and/or speak at the public hearing is voluntary and is not required.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

A handwritten signature in dark ink, appearing to read "Mark A. Farber". The signature is fluid and cursive, with the first name "Mark" being the most prominent part.

Mark A. Farber
Deputy Director

MAF

May 28, 2013

5:00 p.m.

Jones Meeting Center
Johnson City Public Library
100 West Millard Street
Johnson City, Tennessee 37604

PUBLIC HEARING

TRI-CITIES HOLDINGS, LLC, d/b/a TREX
TREATMENT CENTER, CN1303-005

ON BEHALF OF THE STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY:

MARK FARBER
MELISSA BOBBITT
RHONDA FINCHUM
JIM CHRISTOFFERSEN

ON BEHALF OF TRI-CITIES HOLDINGS, LLC:
STEVE KESTER

SPEAKERS IN SUPPORT:

MICHAEL CURRENT
KATHY OSTERTAG
PATRICIA EUNIS
CAMERON GOTTLIEB
TRAVIS SIMERLY
HARVIS HARDISON

SPEAKERS IN OPPOSITION:

RALPH VAN BROCKLIN
ERICK HERRIN
JENNA LEACH
ED SNOWDEN
LISA TIPTON

1 MR. FARBER: All right. I guess we'll get started. Good
2 evening. My name is Mark Farber and I'm the Deputy
3 Director of the Tennessee Health Services and Development
4 Agency. There are additional staff members with me here
5 today. Jim Christoffersen is to my left and he's the
6 general counsel. To my right is Melissa Bobbitt and she's
7 the administrative services assistant. And at the door
8 signing folks in is Rhonda Finchum, our administrative
9 officer. In accordance with Tennessee Code Annotated 68-
10 11-1608(b) Tennessee Health Services and Development
11 Agency is conducting a fact finding public hearing this
12 evening regarding a certificate of need application filed
13 by Tri-Cities Holdings, LLC, d/b/a Trex Treatment Center.
14 The number of this application is CN1303-005. It's for
15 the initiation of opiate addiction treatment through the
16 establishment of a nonresidential substitution based
17 treatment center for opiate addiction at 4 Wesley Court in
18 Johnson City in Washington County. Our role as agency
19 staff this evening is to provide you, the members of the
20 public, an opportunity for anyone to be heard regarding
21 this application. Anyone desiring to make comments on
22 this application may present written testimony or oral
23 testimony this evening. You are strongly encouraged to
24 present written testimony because all written testimony,
25 but only a summary of the oral testimony, will be mailed

1 to the Health Services and Development Agency members for
2 their review approximately seven to ten days prior to the
3 meeting that this application will be heard. These
4 members are the individuals that decide whether or not to
5 grant or deny a certificate of need. I'm going to turn it
6 over to Jim Christoffersen at this point. He's going to
7 talk about support and opposition criteria that the board
8 uses in the review of the application, about our meeting
9 in June, the appeals process, and probably a couple of
10 other things too, so I'll let Jim take it from here.

11 MR. CHRISTOFFERSEN: Thank you, Mr. Farber. Can everybody
12 hear me? Great. First I want to let everybody know why
13 it is that we're actually here as far as the law goes. A
14 certificate of need is required in Tennessee before
15 establishing any type of health care institution. Health
16 care institution has a specific meaning that doesn't
17 include as many things as you might think, but it does
18 cover nonresidential treatment centers for opiate
19 addiction among other things. A certificate of need is
20 also required before initiating the service of opiate
21 addiction treatment provided through a nonresidential
22 substitution based center for opiate addiction, so the
23 certificate of need was filed for that reason. And also
24 by law if any citizen, or institution, or government asks
25 for us to do so on any CON application, we're happy to and

1 by statute obligated, as well, to come out here and have a
2 meeting such as this for the purpose of hearing from the
3 citizens and also any leaders that are interested in the
4 area and any institutions as to what their thoughts are on
5 the project, and that's what we'll have here tonight. And
6 we will, as Mr. Farber indicated, take your views and
7 anything in writing you'd like to submit back to the
8 agency. Now, as far as the appeal process goes for
9 certificate of need applications, this is where things get
10 technical and I want to help you with the technicalities
11 on it. And also if you have any questions after we're
12 through here tonight or once we get back to Nashville, I
13 have my card here for you to call as well and I'm happy to
14 answer questions for folks who are for or against the
15 application. But the technical things that have to be
16 complied with in order to appeal the agency's approval or
17 denial of a certificate of need application is that if you
18 oppose the project, you need to oppose either in writing
19 before the agency's meeting or you need to appear in
20 person at that meeting -- not tonight, but at the agency's
21 meeting in Nashville, Tennessee on the fourth Wednesday of
22 June. A long time ago folks confused a meeting like this
23 for that type of opposition, so it's very important that
24 you know though that if you oppose the project, showing up
25 and opposing it orally tonight does not count for the

1 purpose of appeal, just for the purpose of our taking your
2 thoughts back to the agency. Now, the last thing you'd
3 need to know about appealing an agency decision is that
4 there's a 15-day time frame in which that can be done
5 after the agency makes its decision on the fourth
6 Wednesday of June, if it's heard in June, which is what
7 it's currently scheduled for, and any appeal would have to
8 be filed with our office. And again, I'm happy to provide
9 you with my card which has that information and I'm happy
10 to answer any questions anybody may have after -- after
11 the meeting's over. And back to Mr. Farber.

12 MR. FARBER: Also we have several copies of the application
13 here this evening if you'd like to take a look at it. If
14 you'd like to receive a copy of the application, we have
15 some copy request forms that you can turn into Ms.
16 Finchum. If you provide us an E-mail address, the
17 application can be transmitted to you by E-mail by the end
18 of the week at no charge. If you prefer to have a hard
19 copy of the application, we can -- we can get that to you,
20 too. It'll probably be mailed to you sometime next week
21 as well as with an invoice to cover copying cost. You can
22 also come in and review a copy of the application at the
23 Health Services and Development Agency offices during
24 normal business hours which is 8:00 to 4:30 Monday through
25 Friday. We'd really like anyone that's here this evening,

1 whether you intend to speak or not, to sign in on the
2 sign-in sheet at the desk with Ms. Finchum as you enter
3 the door. If you do intend to speak, please complete a
4 speaker's form and identify whether the testimony is in
5 support or in opposition to the CON application and turn
6 that into Ms. Finchum as well. Anyone intending to submit
7 written testimony may also turn that in to Ms. Finchum at
8 any time during the public hearing. Let me just go over
9 the procedure for tonight's hearing. First, we're going
10 to have a representative of the applicant Tri-Cities
11 Holdings, LLC d/b/a Trex Treatment Center to make a
12 presentation. After that, those individuals who have
13 completed the forms will be called, beginning with those
14 individuals who wish to speak in support of the
15 application, followed by those individuals who wish to
16 speak in opposition to the application. When you come up
17 to the podium, please state your name and present your
18 oral testimony at that time. After the last speaker who
19 has turned in their sheet has spoken, the applicant will
20 be given additional time to respond to any comment made
21 this evening and/or make a summation of the application.
22 When the applicant's response is completed, then the
23 public hearing will be adjourned. So we'll start off and
24 representing the applicant this evening is managing
25 partner, Mr. Steve Kester.

1 MR. KESTER: Thank you, Mark. My name is Steve Kester. I'm
2 the managing parting of Tri-Cities Holdings. And after
3 tonight you'll know why I chose that profession rather
4 than public speaking. I want to thank everybody for
5 coming this afternoon, whether you're in support or in
6 opposition of this project. It's an important topic that
7 deserves this type of community debate and I appreciate
8 your coming here regardless of your position. A little
9 bit about my background, my most proudest accomplishment
10 is my family. I've been married for 23 years. I have
11 three children and I live outside the Atlanta, Georgia
12 area. My background -- educational background, I have a
13 degree in electrical engineering from Georgia Tech and I
14 have an MBA from The Wharton School. I guess to start out
15 tonight I'd like you to imagine if you had cancer and if
16 your doctor prescribed you treatment -- chemo treatment
17 that required you to go every day. And imagine for
18 whatever reason the community that you live in didn't like
19 cancer patients and didn't like the cancer treatment.
20 Imagine for whatever -- it sounds kind of unthinkable, but
21 imagine, if you will, that they didn't and imagine if you
22 had to drive 100 to 200 miles round trip every day to get
23 that treatment. That's what it's like for over a thousand
24 individuals in the Tri-Cities area who are either driving
25 to Asheville, driving to Boone, North Carolina, or driving

1 to Knoxville in many cases every single day to improve
2 their lives, to break the cycle of addiction. I know
3 that. I own two centers in the Asheville area, one in
4 Weaverville, North Carolina. I'm part owner in one in
5 Asheville, North Carolina. And some people have asked me,
6 you know, why do you want to open up in Johnson City,
7 you're just going to be cannibalizing those patients from
8 your other centers, and that is absolutely true. But I
9 don't think there's a person in this room who would listen
10 to the stories of the people who get up at three o'clock
11 in the morning every day in the Tri-Cities area driving to
12 Asheville or driving to Weaverville, driving to Knoxville,
13 driving to Boone, North Carolina to break the cycle of
14 addiction. And it puts a tremendous burden on them
15 physically. It puts a tremendous burden on their
16 families, on their finances, on their employment. And
17 these are people who are trying to get better and trying
18 to break the cycle of addiction, and I can guarantee you
19 if anybody in this room listened to those stories like I
20 have, you know, you'd see it -- you'd see this facility in
21 a much different light. One point of clarification, a lot
22 of -- these are -- this is called an opiate treatment
23 program. A lot of people refer to it commonly as a
24 methadone clinic and I don't like that term for two
25 reasons. One, it implies it's only methadone as the only

1 treatment, and we intend -- in the current centers I'm a
2 part of, and certainly this center, we offer not only
3 methadone, but also a drug called Suboxone, or it's
4 generic name buprenorphine, and also abstinence based
5 treatment. Our philosophy is we meet the patient where
6 they're at. So if the physician and the care team, the
7 nurses and the counselors, indicate that methadone is best
8 for the patient, that's the route we go. If the care team
9 indicates that Suboxone is the best treatment, that's the
10 -- that's the -- and obviously the patient's involved in
11 here as well -- that's the route we go. So to call it a
12 methadone clinic certainly shortchanges it on the
13 treatment options, but also a clinic, I think, doesn't do
14 justice to all the services -- other services that are
15 provided in these types of programs. These services
16 include counseling. 80 percent of the employees in these
17 programs are counselors because a lot of these people
18 struggle with family issues, they struggle with
19 depression, they struggle with employment issues. They
20 have a number of issues that these counselors work really
21 quite tirelessly with. We also do quite a bit of testing,
22 which for the community's benefit they're testing for TB,
23 they're testing for HIV, they're tested for a number of
24 things which is really a benefit for the community to stop
25 those transmissions. They're also -- and this is very

1 important -- doing diversion control techniques, and
2 that's a fancy word which is making sure patients aren't
3 selling their medication out on the street, which is just
4 compounding the drug addiction problem. And there's quite
5 a number of programs in Johnson City and in every town
6 that provide buprenorphine, and hospitals provide
7 inpatient stay, and those are wonderful programs. I'm not
8 here to denigrate the services that are in your city.
9 They play a much needed role in the addiction treatment
10 programs, but there's also opiate treatment programs
11 having a much more comprehensive level of services that
12 meet -- that really serve all the needs. And there's 1300
13 of these clinics in the US and they've been around for
14 over 40 years and there's every major health agency in the
15 world -- in the United States and in the world that have
16 endorsed this treatment, so it's not as though this is
17 some radical new treatment out there. This is a very well
18 established treatment that has acceptance literally around
19 the world. Now, let's get to the problem. The real
20 problem is prescription drug abuse. And the CDC, that's
21 the Center for Disease Control, says that nationally
22 prescription drug abuse is an epidemic. Tennessee ranks
23 at the top or near the top in terms of prescription drug
24 abuse. The State has conducted many studies that show --
25 that highlight the cost, not only the financial cost, but

1 also the social cost of this problem. And eastern
2 Tennessee is even by some estimates, by many estimates,
3 higher than the rest of the state. I encourage everybody
4 to look at The Tennessean today. That's the largest
5 newspaper in the state and they really outline the scope
6 of this problem in eastern Tennessee. Much of the problem
7 stems from these things that are called pill mills, which
8 these are medical practices, and I use that term loosely,
9 that over prescribe prescription pain medication and are
10 really the root cause of a lot of the addiction problems.
11 And thankfully across the country and in the state they're
12 making a lot of progress against these pill mills. The
13 challenge is that there's a drug, heroin, that because of
14 what they're doing to the pill mills, heroin is becoming a
15 cheaper and easier to get opiate than prescription pain
16 medication. And the chief of police in Knoxville has
17 documented -- very well documented the problem that heroin
18 is quickly becoming in the state, and I can tell you
19 that's going to make its way right up the 81 corridor.
20 It's already making its way and that's going to be --
21 that's going to get a grip on this area with significant
22 financial and social cost. So this type of treatment, I
23 think, is very badly needed in this area. Here's the
24 issue. You might think, well, a thousand patients are --
25 from the area are currently getting treatment in

1 Asheville, or in Knoxville, or in Boone, North Carolina.
2 What's the problem? We've effectively exported our
3 problem to other communities. Members of that community
4 might take issue with that, but from your perspective you
5 may think you've exported that problem. The challenge is
6 for every person that makes that 100 or 200 mile round
7 trip, there's two to three people who do not, that can't
8 afford it, their job won't allow it, their family
9 situation won't allow it. And these are the people who
10 are continuing to abuse prescription -- who continue to
11 abuse opiates and those are really the people that should
12 be your concern because statistically 80 percent of those
13 people who are abusing opiates are supporting their habit
14 through crime. And I can't tell you how many stories
15 we've heard. I've heard from parents of a 20 or 22 year
16 old child who said literally the child has pawned
17 everything in the house to support their habit. And for
18 the two to -- for every one of the thousand people, two to
19 three people are committing crime to support their habit.
20 They're leaving their families. They're -- they're tardy
21 or absent at work and they're high unemployment or
22 they're, you know, at much greater risk of HIV or TB or
23 other types of things. You might -- you logically have
24 some concerns about this type of facility opening up in
25 your community. I've opened nine of these centers in four

1 look back. They opened up an opiate treatment program and
2 they looked at -- did at seven year look back and they saw
3 that there was absolutely no reduction in home values in
4 the area and they did see the associated reduction in
5 crime rates. Let's see. The other things that we've
6 heard is that there's plenty of good treatment already in
7 Johnson City with buprenorphine doctors and the hospitals.
8 And I'm not going to denigrate them in any -- there are
9 many fine providers in the area and they're absolutely
10 serving a need in the community, and we would compliment
11 them very well. We would not compete against them. Our
12 desire is not to compete against an inpatient hospital
13 care. It's a totally different level of service. And
14 then the last concern we've heard is the traffic situation
15 and we've heard, you know, concerning numbers, that 500 or
16 1,000 cars per day are going to come to this facility, and
17 that's absolutely not correct. Our best estimates is that
18 there's going to be at worst case scenario 20 cars per
19 hour, which would be 160 cars per day. And from our
20 research, the location that we're trying to site at could
21 easily handle that type of traffic. So, you know, I
22 welcome the debate. I thank you for coming and I guess
23 that concludes my formal remarks.
24 MR. FARBER: Thank you, Mr. Kester. Now I would like to call
25 people who are not -- or individuals who are not part of

1 states and I can tell you they open more with a whimper
2 than a bang. People who are going to these centers want
3 to improve themselves. They're not there looking for
4 trouble. They're not there looking for drugs. The over
5 -- the vast, vast majority of people just want to get in,
6 they want to get their help, they ultimately want their
7 independence back, and that is our objective. Our
8 objective is not to trade one drug for a lifelong
9 addiction. Anybody who's got a conscious, you know, would
10 run away from that type of treatment, and ours are
11 certainly not that way. So the concerns are that these
12 centers are going to bring crime into the community. And
13 for anybody who's interested, I have a study on -- that
14 there is no increase in crime in the community. This
15 article, you know, starts out contrary to concerns, opiate
16 treatment programs do not attract crime in the area. In
17 fact, for anybody who's interested in the study, these
18 types of programs result in a significant reduction in
19 crime. And I have some articles on that, but you can look
20 this up on your Internet. I encourage you to do your own
21 research on the matter. I think you'll agree with me that
22 while you wish these centers weren't necessary,
23 unfortunately they do do a very good job in the community.
24 The other concern is a drop in home values. And Roanoke,
25 Virginia recently did a -- I believe it was a seven year

1 the application or affiliated with the applicant, but
2 would like to speak in support of the application. And
3 the first name I have here is Michael Current.

4 MR. CURRENT: Hello, everyone. My name is Michael Current and
5 I work for the McLeod Center in North Carolina. I'm
6 probably one of the last guys that should be here because
7 we are in competition with this group. However, I'm here
8 to speak as a voice to opioid treatment and say that I've
9 worked in it for nearly seven years and that it is an
10 effective form of treatment. There is a stigma attached
11 to it that we trade one drug for another, and by the time
12 these clients get to our doorsteps, they've crossed the
13 line into addiction a long time before they get to us.
14 The methadone that we prescribe simply sustains their
15 opiate withdrawal, which allows them to focus on other
16 areas of their life. Before they get to us, their whole
17 life was controlled by preventing those withdrawal
18 symptoms which -- which consisted of criminal activity,
19 many other things to obtain their drugs, and opioid
20 treatment helps reduce that. We've seen a lot of people's
21 -- the quality of their lives improve. Counseling is a
22 big part of that. And so if nothing else, I'm just here
23 from North Carolina to say that this is an effective form
24 of treatment and that I am in support of it. Thank you.
25 MR. FARBER: Thank you, sir. Next is Kathy Ostertag.

1 MS. OSTERTAG: Hi, my name is Kathy Ostertag and I'm a
2 registered nurse. I've worked in addiction treatment for
3 close to 14 years. I have worked with Mr. Kester in the
4 past. We don't currently work together now. I was
5 associated with the two facilities that he has in the
6 Asheville area. I was the clinic director for one and
7 instrumental in opening up the other facility, and I can
8 tell you that he has the best of intentions to serve this
9 community and be a good neighbor to everyone. I mean, you
10 can't imagine the kind of change that you see in people
11 that come into a facility such as the one that Mr. Kester
12 is seeking to open here. It changes lives. I've worked,
13 well, almost 14 years in this same mode of treatment.
14 Currently I'm not working in that treatment mode right
15 now, but I can tell you that we were very good -- we're
16 good neighbors. The facilities are excellent neighbors.
17 Most of the businesses directly associated with these
18 facilities are not even fully aware of what's going on
19 there. There is no increase in crime whatsoever in these
20 areas. We're good neighbors. We're well liked, have very
21 deep community interest. The other thing that I wanted to
22 talk about was in the 14 years working in opioid treatment
23 programs -- and I'm saying that as opposed to methadone
24 maintenance treatment programs as some people call them,
25 because they're not only using methadone, also

1 buprenorphine known as Suboxone or Subutex -- provides,
2 you know, both medications. But when the patients come
3 into the facilities, they are closely followed by a
4 substance abuse counselor. And I'm an addiction -- a
5 certified addictions registered nurse, also worked as a
6 counselor for many years. And these clients are very
7 closely followed by their counselor. They work pretty
8 much as case managers. So if you have a client coming in
9 who's having family issues, financial issues, issues with
10 their job, issues with educational needs, whatever the
11 case may be, we step up to the plate and sit down with
12 clients and try to help them figure it out. We're not
13 just there to hand out a substitute medication. This is a
14 comprehensive treatment program that provides a whole
15 range of services. We make lots of referrals to
16 physicians, other mental health agencies throughout the
17 community when we discover that patients have unmet needs
18 [sic] -- needs that are unmet, sorry. Excuse me. I'm not
19 used to talking in front of a lot of people. So we might
20 refer people to psychiatrists, or mental health agencies,
21 or social services. We work closely with social services.
22 If we have a client that has an ongoing case with social
23 services, say with child needs, things like that, we work
24 closely with them. We're always available. We usually
25 establish -- I mean, all the facilities that I've been

1 associated with we establish a good rapport with police in
2 the area, with all the state, sheriff's department, local
3 agencies. We have an excellent relationship and we want
4 those relationships. We wanted to go out into the
5 community and educate and bring people in. But not only
6 that, I mean, okay, I probably have seen in almost 14
7 years working in this field in opioid treatment programs
8 probably close to 10,000 people come through the doors of
9 these facilities and initiate treatment, and this is all
10 in the Asheville area. And I am -- I don't have hard
11 numbers, but I'm telling you right now, probably 30 to 40
12 percent, and that's a conservative number, are from this
13 area of Tennessee. Okay. We have families that come
14 there from Tennessee, families with young children. This
15 treatment has changed their lives. They have jobs, they
16 have the respect of their family again. They've even in a
17 lot of cases gotten their children back when they've been
18 taken away with social services. They've changed their
19 lives because they're not just getting methadone or
20 Suboxone treatment, they're getting somebody to help them,
21 coach them through the problems of their life. They're
22 getting a comprehensive program. So this is an example,
23 and this is not an unusual example, this is a very common
24 example. Young family, mother and father, young kids,
25 maybe one and two years old, right, he has a job he has to

1 be at, or they have older children that have to go to
2 school. They might -- their alarm might ring at one
3 o'clock in the morning when we're all still sleeping.
4 They get up, they get in their car, they drive all the way
5 to Asheville with those kids in the car, they get their
6 medication, and they see their counselors. These clinics
7 open up very early in the morning in order to provide
8 people with services at hours that they can still maintain
9 their lives. So they go there, they wait in the parking
10 lot for the business to open. Because they've had to
11 drive such a long way, they want to make sure that they're
12 first to get services when they get in the door. They
13 have drug testing, they may see their counselor that day,
14 and then they get back in their car and they drive all the
15 way home again. And then they get ready for work, and
16 then they get their kids ready for school, and then
17 they're out the door at eight o'clock, 7:30 in the morning
18 having their lives just like the rest of us do, but
19 they've already had a full day before they even get to the
20 point where most of us are starting our day. They've
21 already had a whole entire day that's devoted to keeping
22 clean, and staying off the streets, and bringing their
23 families back together. When somebody tells you this
24 facility has saved my life, it has saved my family and my
25 kids, that's something that it just drives home to your

1 heart. I can't tell you -- I can't speak enough about the
2 need in this area. The clients that come to these
3 facilities are people just like you and me. They could be
4 the woman sitting next to you in church, could be one of
5 your kids' teachers. Would you rather that they continue
6 on in an addiction without any help, without any support,
7 without any mental health services providing -- the woman
8 at the grocery store who's checking you out. Addiction
9 has no discrimination. It affects everybody and it's not
10 just the people who are addicted, it's their whole
11 families. It's the places that they work. It's their
12 health. It's going into the emergency room seeking drugs
13 at all hours of the day and night tying up our health care
14 system, for example. I mean, I've talked to numerous
15 people in other areas where their emergency room visits
16 each year number in the thousands and thousands because
17 people are coming in those doors doing nothing but seeking
18 drugs because there's nothing available in their
19 communities for treatment -- and affordable treatment.
20 These treatment programs are affordable for average
21 people. They can pay on a daily basis, a weekly basis, a
22 monthly basis. It's not costing them ten or \$20,000.00 a
23 year to go to some inpatient facility that they simply
24 can't afford. So if a patient goes into a doctor's office
25 and receives a prescription for Suboxone, they go in there

1 once a month, the doctor has a waiver, he can see a
2 hundred patients. If a patient comes into an opioid
3 treatment program, for example, and they're seeking
4 Suboxone, they're covered by the same limit. The
5 physician may only have a hundred patients, but if it goes
6 over that number in an opioid treatment program we can
7 take those patients and put them on Suboxone, which is
8 either -- buprenorphine is the generic name for that --
9 because there is no limit when they're engaged in an
10 outpatient treatment program for opiate addiction. They
11 would be under the same guidelines as the patients taking
12 methadone. They would be required to come to the clinic
13 every single day. They would have to meet with their
14 counselor very frequently. And if a patient is in crisis,
15 they don't need to call up and make an appointment
16 somewhere and wait weeks and weeks to get in or present
17 themselves at the emergency room. They simply come to the
18 clinic and they let the secretary at the front know "I'm
19 having a crisis and I need to see my counselor today."
20 Each and every counselor saves time in their day for
21 crisis intervention. And as the program director, I was
22 often involved in crisis intervention and I took it very,
23 very seriously. We're on call 24/7. Those patients can
24 call the clinic anytime and get help that they need to
25 talk to somebody. Generally in the facilities that I

1 worked at that person was me because I could not only
2 address their medical needs, but their counseling needs
3 too. I -- many times answering the phone after midnight
4 and spending countless amount of hours on the phone trying
5 to help people and talk them down for whatever is going on
6 in their lives. There's no need to be afraid of bringing
7 a program like this to your community because your
8 community needs it and the clients that this facility
9 would serve are already here. They're already here and
10 they're living right in your community today, but they
11 don't have any help. They need help and it's not fair
12 that they have to drive all the way to North Carolina to
13 get it. And I can tell you that Steve is a great guy and
14 he will run a top notch facility -- patient centered
15 facility and he will be concerned about what is happening
16 in this community. Thank you.

17 MS. LEACH: May I ask you a question?

18 MS. OSTERTAG: Sure you can.

19 MS. LEACH: All right. When the patient leaves...

20 MR. CHRISTOFFERSEN: Excuse me.

21 MS. OSTERTAG: Oh, I don't know, can she ask me a question?

22 MR. CHRISTOFFERSEN: It'd be best to do that after the
23 meeting. Thank you.

24 MS. OSTERTAG: That's fine.

25 MR. FARBER: This is just an opportunity for individuals to

1 present testimony here this evening. It's really not
2 designed to be a question and answer session, but you're
3 more than welcome to speak with her after the hearing.
4 Okay. The next person I have on the list is Ms. Patricia
5 Eunis.

6 MS. EUNIS: Excuse me. I've got to get these metal knees to
7 working. Hi, my name is Patricia Eunis and I thank you so
8 much for allowing me to be able to come and speak to you
9 today. Johnson City is my native home. I was born and
10 raised here. I took my LPN training here in 1959 and I
11 went to Nashville and took the test and got certified as
12 an LPN in 1961. My son was born here in 1960. His sister
13 was born in Nashville in '63. And I made a mistake and
14 went to Baltimore, Maryland in '65 following a divorce.
15 And I met and married my second husband and we had a
16 daughter who is going to be 37 this October. My son died
17 April 15th of 2010. He was living and had been working in
18 Hastings, England. He had been -- prior to his death, he
19 had been clean from drugs -- street drugs -- for 25 plus
20 years, but he was an alcoholic. And he did -- he did
21 confirm to me that he had tried every street drug known,
22 just because -- just because he could, just because he
23 wanted to, and he had experimented with street drugs and
24 drinking at the age of 12. His sister Margie died January
25 4th of 2011. She lost her six years of sobriety, being

1 clean and sober from drugs and alcohol, because she was
2 grieving the death of her brother. She had no one up in
3 Baltimore for a support system because I was living in
4 Tampa, Florida and then my husband and I moved here from
5 Tampa in 2006 because this is where I needed to come back
6 home to my roots. Margie died because she was taking
7 prescription medications and when she lost her sobriety
8 sometime in November of 2010 -- which November is the
9 holiday month of Thanksgiving -- she and her brother
10 always talked long distance for Thanksgiving and for
11 Christmas, and she couldn't handle it. She knew she
12 wasn't supposed to drink and take her medications;
13 however, when you have enough alcohol in your system, your
14 brain does not work right. The medical examiner said that
15 she had a .10 alcohol level -- blood alcohol level in her
16 system and mixed with her bedtime medications it was not
17 an overdose. They counted every pill in her bottle -- in
18 her bottles of medicines that had just been filled on
19 Monday, the 3rd of January and everything was there except
20 for what she had taken for that morning and that night.
21 Morphine and Vicodin for breakthrough pain, trazodone for
22 bedtime, and Ambien for sleep were found in her system.
23 So she died because she mixed alcohol and prescription
24 medications. I cannot begin to tell you how many mothers
25 and grandmothers are out here in this Tri-Cities area

1 alone. I'm not talking about state wide, I'm talking
2 about right here in east Tennessee in the Tri-Cities area,
3 how many mothers and grandmothers, fathers, step-fathers
4 are going through the pain of losing a child or a
5 grandchild because there is no help for them. Why? Well,
6 all three of my children got introduced into the drugs at
7 the young age of 12, on up into their teen years. They
8 married, their adult years were filled with drugs. Mama
9 cut the ties and left home. I was living in Baltimore,
10 Maryland, had been living up there for 21 years, raised
11 those children. And I was told by a drug addicted son,
12 "Leave us alone, you raised your kids and didn't go a very
13 good job, now leave us alone and let us raise ours." So I
14 cut the apron strings and I left. I lived for two years
15 in Texas and then I went to Florida and I lived for a
16 number of years in Florida in Tampa. About once every
17 three months my daughter would fly down to Tampa. My
18 oldest daughter Margie would fly to Tampa because she knew
19 that mama was a Christian and she knew that mama could
20 help her get clean again because mama would go with her to
21 the NA meetings, to the AA meetings. Oh, yes, she
22 relapsed many, many times. She relapsed and every time
23 she relapsed, she came to mama. I took her to the
24 meetings. I didn't take her and drop her off, I took her
25 to meetings that were open to the public. I was with her

1 in those meetings. I heard the stories and they are
2 horror stories. Many, many people were telling the
3 stories about how they wish they could get rid of their
4 addiction and if it weren't for AA or NA -- they wished
5 that they had someplace where they could go to help them
6 get off of prescription medications and street drugs --
7 heroin, one of the major ones, crack cocaine, another
8 major one. These meetings broke my heart and they just
9 about broke me. And I went to many of the meetings and
10 some of the young men that were in those meetings would
11 come up to me and give me a hug and say, "Thank you for
12 being here for us." Now, I haven't been into any meetings
13 here in Johnson City, but I can tell you I know a lot of
14 the homeless people out here. I've met a lot of the
15 homeless veterans and they will tell you the same thing
16 I'm going to tell you. This clinic is very much needed.
17 They can't get help through the VA. They cannot get help
18 through the VA. Can you hear that? Please hear that.
19 They do not get help through the VA. Yes, we have
20 programs here and, as Mr. Kester said, I do not want to
21 denigrate those programs, but I will say this, because of
22 the budget cuts there's nobody that can afford these
23 programs unless you're born into a family that's got
24 money. Now, what are these people who are addicted --
25 where are they going to get the money? They're going to

1 steal it from their own parents, their own grandparents.
2 They take things out of the house and pawn them for the
3 money for their habit. But they will tell you face to
4 face, "I wish I could get help, but I don't have the money
5 to get help." Why not? Because there's nobody that
6 cares. Nobody cares, and I believe that, nobody cares.
7 We do have a good program through Frontier Health, but
8 they can only help just so much because of budget cuts.
9 Not everyone has the ability to get on TennCare and
10 TennCare will not take care of these drug addicts' habits.
11 Whether it's street drugs or whether it's prescription
12 drugs, they don't care. And with this -- yes, I will say
13 it -- with this sitting President and this Affordable
14 Health Care Act, is putting things way down in the tube,
15 so I applaud Mr. Kester for what he wants to do for the
16 Tri-Cities area, for east Tennessee. Now, to get back to
17 this clinic, I've done some research and I've told my
18 daughter's story with her permission. Her name is
19 Kimberly. She's my youngest daughter by my second ex-
20 husband. She was a drug and alcohol addict. She lives in
21 Baltimore, Maryland and she does go to a clinic up there.
22 It is a methadone -- she is on methadone. It's the liquid
23 methadone and if you want to know, there's many different
24 doses. Methadone comes in tablet form and it comes in
25 liquid form. She chose the liquid form because it's

1 easier on her stomach. When she first started the
2 program, it was because she was ordered to go into the
3 program. A judge was going to send her to prison for five
4 to ten years for failure -- FTA -- failure to appear in
5 court. She ran -- she ran from the cops. She's got a
6 record longer than my arm. I don't know how many times
7 she's been in jail, how many times I tried to find her,
8 but then I wised up and I said okay, she's probably in
9 Baltimore city jail. So I'd call down in Baltimore city,
10 "No, she's not here." Check with the county, "Oh, yes,
11 we've got her." Do you have any idea how that feels, to
12 know that your child is in jail because they stole
13 something again for their heroin fix? Well, I asked
14 Kimberly about a year ago, "Why did you decide to come off
15 of heroin? Why did you decide to go into the program?"
16 And she told me, she said, "Mom, I had no choice. They
17 were going to send me to prison for five to ten years, but
18 the judge decided to give me one more chance and it was
19 going to be the only chance, so I chose to go into the
20 methadone program, to go into rehab." Today, here it is
21 almost two years later, she's trusted, she has made it to
22 level seven. I'm not sure if you're familiar with level
23 seven. You know what's involved. Kimberly is doing so
24 good with the methadone program. She goes in and she does
25 her urine testing. If anything shows up, she knows right

1 going to be -- or like her sister and she's going to have
2 multiple ruptured discs. At this time she is taking 120
3 milligrams of the liquid methadone and this holds her.

4 MR. FARBER: Excuse me. Ms. Eunis, we have several people
5 that would like to speak this evening and we appreciate
6 you sharing your daughter's story, but if you could try to
7 summarize.

8 MS. EUNIS: I will summarize right now, sir. Thank you. Upon
9 my daughter's advice and my advice -- my husband is also
10 -- who is not here, because of a medical issue he could
11 not come. We know that Mr. Kester is in the right place
12 for the right time. This clinic is needed here in this
13 local area. There are guidelines that will be in place,
14 and being a retired LPN I think I might be one of the
15 first ones in line that says if I hear of anybody selling
16 methadone on the street, I will approach Mr. Kester about
17 it and we'll have a go round about it. I -- please,
18 please, I encourage you all, take this information back to
19 Nashville and let them know there are many, many parents
20 and grandparents who want to see their children live,
21 their grandchildren live a good life, free from these
22 addictions. Methadone is harmless. It has far less side
23 effects. And I thank you for your time.

24 MR. FARBER: Before I call the next individual, just in
25 general, just remember we have a number of people who

1 away she's going to be kicked out and that's forever
2 because she had been given so many chances. Now she said
3 -- when I told her what Mr. Kester said, that he had found
4 about a thousand people, she says, mom -- and I'm going to
5 have to read this because I can't remember her words
6 exactly. "That is crazy. If there are about a thousand
7 known addicted people, then you can double or even triple
8 those numbers of people who are addicted because they have
9 no way to get out of their addiction because they have no
10 money for those trips. So they stay addicted and by
11 staying addicted they commit crimes, crimes against you,
12 against your neighbor, other neighborhoods where she can't
13 be seen or found, or he can't be seen or found; homes
14 broken into; cars broken into. Mom, they just do not know
15 of the true number of people who are addicted because they
16 stay pretty much underground and they do not have
17 insurance that will pay for doctor visits and pay for
18 prescription pain meds." She's working the program and
19 the program is working for her. She's going to stay in
20 the program upon the advice of her counselor. She was in
21 a car accident years ago, she messed up her back. Because
22 she cannot work, she has no insurance and so far she has
23 not qualified for Medicaid program. They've turned her
24 down several times. She really needs to have that back
25 surgery done or she's going to be old like me and she's

1 would like to speak this evening, so if you could -- if
2 everybody could keep their comments to, you know, five,
3 ten minutes max would be greatly appreciated. We'd like
4 everyone that wants to speak to have the opportunity to
5 speak this evening. The next individual on my list is
6 Cameron Gottlieb.

7 MR. GOTTLIEB: My name's Cameron Gottlieb. I'm a resident of
8 northeast Tennessee. I'm an MMT patient. I attend a
9 clinic in Weaverville, North Carolina. All I can say is
10 methadone saved my life. I function in society. I hold
11 down a full-time job. I go to school part-time. Before I
12 entered the program, addiction -- the cycle of addiction
13 is -- I don't even know how to explain it in a small
14 amount of time. It's a nightmare. I could summarize it
15 is a nightmare and unfortunately the resources haven't
16 been available in northeast Tennessee for a program like
17 this. And I would just like to say I am in support of it
18 and I just beg the committee to please look into
19 everything before making a decision. Thank you very much.

20 MR. FARBER: Thank you, sir. Travis Simerly.

21 MR. SIMERLY: Hello, my name is Travis Simerly. I'm 34 years
22 old and I've worked in the construction industry since I
23 graduated -- since before I graduated high school. And
24 I've seen numerous members of my friends and people in the
25 community and just -- opioids, they're -- it's -- the

1 addiction to opioids, it's taken over everything. I mean,
2 I've lost so many people to the addiction of doing pills
3 and everything. And it's -- it's just -- it's horrible.
4 They can't get help. They want to get help. Like people
5 have said before, you know, they don't -- they don't have
6 money to attend the inpatient facilities and a lot of them
7 can't get on a -- can't see a Suboxone doctor because of
8 the hundred patient limit and there's just a huge need for
9 -- for -- you know, what Steve Kester is going to open up
10 this clinic here. And I really hope that you take
11 everything into consideration and listen to all these
12 testimonies and approve it. Thank you.

13 MR. FARBER: Thank you. Does Harvis Hardison wish to speak
14 this evening?

15 MR. HARDISON: First off, I want to say Frontier Health has
16 lost in the past two and a half years two of their three
17 people that can help counsel people on Medicare. They
18 don't have but one Medicare certified person right now.
19 They were trying to get another one. I don't know if they
20 have yet or not, but not the last I heard. And I
21 appreciate those who have come before me because they
22 pretty well covered most of what I was going to say. A
23 few years ago there was somebody trying to bring such a
24 clinic in, to just go a block and a half over that way on
25 Fairview, but no, the Christians at Central Baptist and

1 the other neighborhood churches -- these are country clubs
2 for saints -- they don't want give us your tired, your
3 poor, your hungry, let alone drug addicted. There's a
4 book about Johnson City printed a hundred years ago by the
5 commercial club. It says there's no -- they use the word
6 sectional repeatedly rather than regional. They said
7 there is no sectional feeling here, no north and no south,
8 and no east and no west, and every tub must stand on its
9 own bottom. The same mind set is here today. They go on
10 to say just before or after a page or so about the
11 Christian community, that unworthy people are no more
12 welcome here than anywhere else on earth. I'm sorry, I
13 had a head injury. I stammer a little bit and whatnot.
14 But I have a friend at my house right now. A couple times
15 a month or so he begs to come in from the elements. He's
16 homeless right now. He's got a drug problem. If he
17 hasn't burned my house down while I'm here, I'm lucky. I
18 tell him I cannot take any cigarette smoke in my house and
19 whatnot, but when he gets messed up, and as I left my
20 house he was -- to go to a dental appointment a while ago,
21 he was stealing away my mouthwash. I couldn't even rinse
22 with mouthwash before I left because he's chugging it.
23 And, you know, Lord knows he can't find his Cadillac for a
24 couple weeks now because he loans it out to get drugs. So
25 I don't think he's running off with much of my old and

1 antiquated unworthy electronics or anything to a pawn
2 shop. I hope not, but he needs help. He can't get any
3 help around here. Frontier Health has many people they've
4 had to turn away that are on Medicare because they don't
5 -- they can't recruit one. Nobody wants to go where they
6 have to work for a big corporation where they have to dot
7 there is and cross the Ts, and that's all they're about
8 there anymore. So there just needs to be some things done
9 here, and you're talking about a commercial industrial
10 area. If anybody in here stands up and says that they
11 don't -- that they're a Christian and they aren't going to
12 allow that, that's just asinine, it's ridiculous. Now,
13 Dr. Scott Caudle got something opened about another block
14 and a half or so over that way at the corner of Unaka
15 where I went to nursery school at the northeastern corner
16 with Montgomery. I don't know what's happened to that. I
17 guess he was shot down. It wasn't methadone, it was one
18 of these other similar things, but it's just -- there are
19 your friends and neighbors, family members. There's --
20 there's two doctors I know of, one of them's office is
21 right over here, have lost children to drug addiction. I
22 mean, it's sad. You know, on the other hand, I'm kind of
23 for legalization of marijuana. I've never even tried a
24 cigarette. That killed my dad. I hate tobacco with a
25 disdain and occasionally when my friend's climbing the

1 walls and he's there, I have succumbed in the past year or
2 so to buying maybe about three packs of cigarettes. But
3 anyhow, I just hope that what you all -- he -- he admitted
4 he's been doing cocaine ever since shortly after I met him
5 about a decade and a half ago. He's -- you know, he's one
6 of these regional all state athletes. He was a football
7 and basketball player and, you know, after they're done
8 with all that glory and ballyhooing, you know, they're out
9 on the streets if they don't have much family. I mean,
10 there had been a -- let's see. I met him and he was
11 living with two aunts, one was bedridden, the other one
12 was a hunchback, and the daddy died of a bee sting. There
13 had been a divorce and mother was done with her sons the
14 day they graduated and, you know, he has nobody. Both the
15 aunts have died. I became actually more friends with the
16 aunt over the years until she died about two summers ago,
17 but now he -- I knew he would kind of come to me and
18 expect me to pick up the ball enabling and coddling him.
19 I'm not going to do it, but too much of what goes on with
20 the churches here, I think, is a bunch of hooey and
21 hypocrisy. I mean...

22 MR. CHRISTOFFERSEN: Sir, if you could, please limit the
23 personal attacks.

24 MR. HARDISON: Well, I'm a Christian, but...

25 MR. CHRISTOFFERSEN: With due respect, this is about the

1 merits of the application.

2 MR. HARDISON: Well, what I'm upset about is, I mean, it says
3 in God we trust in our country, but I don't know what God
4 it is these people in Johnson City...

5 MR. CHRISTOFFERSEN: Sir, again, we have people in this
6 room...

7 MR. HARDISON: Okay, sorry, that's all.

8 MR. CHRISTOFFERSEN: ...with different opinions, so there's no
9 point in...

10 MR. HARDISON: That's fine.

11 MR. CHRISTOFFERSEN: ...attacking half the room.

12 MR. HARDISON: But they need to think twice before they turn
13 their back on people. Thank you.

14 MR. FARBER: Okay. We're going to go on to the next point in
15 our agenda where we'll be calling those individuals who
16 wish to speak in opposition to the application. I'd like
17 to start with Mayor Van Brocklin.

18 MR. VAN BROCKLIN: Mr. Farber, I am Ralph Van Brocklin. I'm
19 mayor of Johnson City. I appreciate you and your staff
20 being here today taking the concerns of our citizens into
21 account this evening. You will certainly hear from some
22 of our citizens this evening that they are not happy about
23 the proposed methadone clinic being located here in
24 Johnson City. This evening you won't hear from local
25 government that perspective, although I did think that it

1 was important for you to know that at the certificate of
2 need hearing on the 26th of June, you will hear from us in
3 opposition to this. So that's really the only comment
4 that I wanted to make, but we do appreciate you being here
5 and listening to these concerns.

6 MR. FARBER: Thank you, sir. Erick Herrin.

7 MR. HERRIN: My name is Erick Herrin. I am legal counsel to
8 the City of Johnson City in a lawsuit filed by Tri-Cities
9 Holdings, LLC against the City in the Federal District
10 Court in Greeneville, and against the Board of
11 Commissioners and against its Board of Zoning Appeals. We
12 had a hearing in that case just this past Friday all day.
13 Many of the issues in that litigation involved reference
14 to the certificate of need and application submitted by
15 Tri-Cities Holdings. We would anticipate a court order
16 within a couple of weeks that we think should be of
17 interest to the certificate of need process. As our mayor
18 has mentioned, we will be presenting the City's position
19 at the June 26th hearing. There's several members that
20 you should be aware of of the city government that are
21 present and we are fully engaged in this process. Thank
22 you.

23 MR. FARBER: Thank you. Jenna Leach.

24 MS. LEACH: Thank you for allowing me to speak. Correct me if
25 I'm wrong, I believe this lady said that methadone was

1 harmless. This is my son's death certificate. He died of
2 methadone intoxication seven years ago. He got it from a
3 friend who was going to the Asheville clinic. I've still
4 got the little whitish bottle that the pink liquid was in.
5 And this friend sold it or gave it to him. I thought it
6 was a controlled substance. How did it even get out of
7 the -- out of the clinic? Methadone killed my son. I
8 think Mr. Kester wants to make it easier for the addict.
9 That's swell. And I think it's just a business
10 opportunity for him and I think that Suboxone and
11 methadone are just substitutes. It's a controlled
12 substance and it is not harmless.

13 MR. LEACH: And I feel like, say, 160 people a day come in and
14 get the treatment, well, then they're out the door and
15 they're on the street. I don't want to be driving on the
16 street when they're DUI.

17 MS. LEACH: My question was when they come back from the
18 clinic, are they high on methadone because they've been
19 given their methadone?

20 MS. OSTERTAG: No.

21 MS. LEACH: Then how did this methadone get -- I mean, is it
22 not monitored? It's a controlled substance.

23 MS. OSTERTAG: Yes, it's very highly regulated.

24 MS. BOBBITT: Ma'am, can you talk to the mic, please?

25 MS. LEACH: Okay. I'm through. I'm just -- I'm angry and,

1 you know, this -- it's my baby, he's gone.
2 MS. EUNIS: But your baby...
3 MR. CHRISTOFFERSEN: Ma'am, let's please not address each
4 other. Thank you.
5 MS. EUNIS: I'll talk to you after the meeting.
6 MR. FARBER: Ed Snowden.
7 MR. SNOWDEN: I'm Ed Snowden. First of all, my condolences,
8 ma'am.
9 MS. LEACH: Thank you.
10 MR. SNOWDEN: I wasn't going to say anything about methadone
11 -- about what it does. I have a daughter who is a drug
12 addict. She goes to Asheville -- did, she's off now.
13 Every time she went over there just about coming back --
14 she's had a total of four wrecks coming back stoned. You
15 tell me that they're not stoned when they come out.
16 That's malarkey. But my main thing today is where they're
17 putting this methadone clinic bothers me. On this road I
18 have a business and we have trucks and trailers coming in
19 and out every day. We're on a part of the road right past
20 Miller Tire. We put people out there to try to stop
21 people so our trailers can pull in and out, don't do any
22 good. People whip around that curve anyway, right around
23 our men. You've got EMS, ambulance service right next
24 door to me, constantly in and out. You have the
25 unemployment office right up the street, almost across

1 from where they're at. You have the IRS, heavily traveled
2 road, truck access. I mean, a church, you've got a
3 juvenile detention center right up on the left before you
4 get to their building. You have Thomas Construction
5 Company, big tractors, dozers, all this equipment in and
6 out, dump trucks. Coca-Cola Company, their big trucks
7 coming in and out all day long. You've got the rehab --
8 Quillen Rehab Center and then where one of the doctors
9 that used to -- was on cancer, the center where he was at
10 now is -- it's full of a lot of different businesses, but
11 Mountain States has got facilities in there now. It just
12 goes on and on and on. This road cannot bear any more
13 than what we've got now. We've got too much traffic on
14 this road the way it is and it's totally business. The
15 City -- I'm glad you guys are here. We've asked them to
16 put signs up, trucks and trailers entering highway,
17 roadway. We haven't got it. I've had one man almost got
18 hit, if he hadn't jumped over there off into the bushes.
19 People travel too fast on that road the way it is. And if
20 we've got a methadone clinic there, 160 more people a day
21 they say. That's now -- that may be now, but what's it
22 going to be down six months to a year from now? We just
23 cannot handle any more traffic on that road. And I beg
24 the State for once to do something that's right for the
25 people in this area. If they want to put a methadone

1 clinic, put it somewhere where there's nothing, no lot of
2 traffic running. We've got a park over here, a medical
3 park. Build a building in there. Put it in there. If
4 it's medical, put it in there. But I appreciate it, thank
5 you.

6 MR. FARBER: Thank you. Lisa Tipton.

7 MS. TIPTON: Hello. I appreciate the opportunity to get to
8 speak to you tonight as well. And I'm the executive
9 director of a nonprofit organization called Families Free
10 and we are actually in the neighborhood where Mr. Kester
11 would like to open his facility. It was interesting to
12 listen to him speak.

13 ***OFF THE RECORD***

14 MS. BOBBITT: Okay. Could you start over, please?

15 MS. TIPTON: Sure, I'll try to remember what I said.

16 MS. BOBBITT: Thank you.

17 MS. TIPTON: My name's Lisa Tipton and I'm the executive
18 director of a nonprofit organization called Families Free.
19 We have been in Johnson City for seven years. I started
20 this agency myself and it was mostly in response to a huge
21 problem that I saw as a social worker of drug addiction in
22 northeast Tennessee. We are actually within a mile of
23 where Mr. Kester is proposing to open up this clinic and
24 there are actually two licensed alcohol and drug treatment
25 facilities within a mile of his location who are nonprofit

1 organizations and operate with an alcohol and drug
2 treatment license, which is radically different than what
3 Mr. Kester is proposing. We are licensed by the State of
4 Tennessee, as is Comprehensive Community Services, which
5 is actually on the same street as Mr. Kester. So as far
6 as someone who has heard stories of families who are
7 impacted by incarceration -- or, I mean, I'm sorry, by
8 drug addiction, Families Free currently serves about 175
9 individuals in the northeast region through work with the
10 Department of Mental Health and Department of Childrens
11 Services and we offer treatment services four days a week
12 at our facility that are abstinence based. We have
13 licensed counselors, we have a psychiatrist. And I take a
14 lot of offense at what Mr. Kester said because there are
15 people sitting on either side of me in this room who also
16 work with people with addictions each week. We hear the
17 stories. We know what the needs are and we are adamantly
18 opposed to a for profit business coming in to, in my
19 opinion, capitalize on the devastation that's impacting
20 our region by substance abuse. We have several
21 buprenorphine clinics. There are many places to get
22 medically assisted treatment in Johnson City and we also
23 receive referrals from one of those clinics to provide
24 intensive alcohol and drug treatment along with the
25 medically assisted treatment. So there are services here

1 in Johnson City where if people wanted to private pay --
2 we're grant funded, and we do have people who can private
3 pay, and it would be much less than the cost of methadone
4 treatment. I've worked with many individuals over the
5 years who go to North Carolina to the clinics and it's a
6 very sad state and, yes, they do get their children up at
7 one o'clock in the morning and they do drag them in and
8 out to see them. And most of those families that we've
9 been involved with the Department of Childrens Services
10 did not have good outcomes. So I would just ask that you
11 do consider all the services that are available in our
12 community and are available in very close proximity to
13 where he proposes to open up this center.

14 MR. FARBER: Thank you. Is there anyone that has not filled
15 out a speaker's form that wishes to speak in support or
16 opposition to the application at this time? If not, then
17 Mr. Kester, you have some time to do some summation.

18 MR. KESTER: Okay. Again, I'd like to thank everybody for
19 coming out today whether you're for or against this --
20 this initiative. And I won't repeat a lot of what was
21 said today, I'll just try to address some of the concerns.
22 And the first is, you know, Mr. and Ms. Leach, I'm very
23 sorry for the death of your son. As the father of three
24 kids, I can't imagine what you all went through. And I
25 agree with your statement that methadone is absolutely --

1 if not handled properly can be a very dangerous substance,
2 in fact leading to overdose. There are a number of
3 methadone overdoses in this country. It's alarmingly high
4 and I encourage you to look at the source of those
5 methadone overdoses. I understand...

6 MS. LEACH: It was called methadone intoxication...

7 MR. KESTER: Right.

8 MS. LEACH: ...on his death certificate.

9 MR. KESTER: Absolutely, and I'm not disagreeing at all that
10 it was improperly diverted from a patient. They had a
11 take home dose and they probably -- I don't know the facts
12 in this case. They probably sold it on the street. I can
13 tell you every opiate treatment program in this country
14 worries about that. You try to safeguard that. We're
15 very highly regulated at the state and federal level and
16 sometimes, you know, the -- you know, the system fails and
17 in this case it failed for you. The overwhelming -- there
18 are a number of methadone overdoses in this country every
19 year like that of your son. And the source of those --
20 the number one source are pain clinics and hospitals, the
21 methadone diverted out of those facilities. I'm not
22 denying that it doesn't happen in methadone clinics. It
23 absolutely does and it absolutely did in your son's case
24 and I'm sorry for that. Most of the methadone overdoses
25 in this country are actually outside of opiate treatment

1 programs but, you know, our state highways are regulated
2 and speeds are, you know, posted. And there tries to be
3 compliance, but unfortunately there's motor vehicle deaths
4 as well, and I'm not trying to compare the two. In fact,
5 the CDC just came out with a report. For the first time
6 in this country's history the number of deaths --
7 accidental deaths from motor vehicle deaths was overpassed
8 for the first time in history with prescription drug
9 overdoses. And, you know, your son's situation was
10 clearly tragic, but for every person in this area that's
11 getting treatment, two to three want treatment but don't
12 get it for whatever reason. And these are people who are
13 overdosing as well on prescriptions and we're trying to --
14 we're trying to bring services to that community. So I'm
15 sorry, you know, as a father of three, you know, my heart
16 breaks for you. And, you know, I pledge if this facility
17 is open, I will do everything, you know, within power to
18 make sure patients are compliant, but that's something
19 every operator in this country worries about. To Mr.
20 Snowden, I understand your concerns about traffic. We've
21 worked with the landlord, and by our estimate -- by the
22 landlord's estimate, the amount of traffic at our facility
23 is comparable as to when it was -- operated as a Sears
24 rental and repair shop where they had a similar amount of
25 traffic, only in this case it was trucks on that road. So

1 again, the traffic situation according to the Johnson City
2 engineer could be handled by what -- by our worst case
3 traffic scenario. I would also mention that we have
4 worked -- tried to work tirelessly, you know, with the
5 City to try to get reasonably accommodated, find the best
6 location we can. And repeatedly the phone calls went
7 unanswered and the meeting requests weren't met, so we
8 have tried with our best faith efforts and we continue to
9 want to work with the City to find a location. Ms.
10 Tipton, thank you for providing drug and alcohol addiction
11 treatment services in the city. There are many fine
12 doctors who are providing buprenorphine in the city and
13 they're doing a good job. The hospitals -- I've talked
14 with hospital administrators at, you know, Frontier, at
15 Mountain States, and at Johnson City or Wellmont, and in
16 every case, you know, there's been a doctor or a
17 representative from the hospital who said, "Please bring
18 these types of treatment services to the city. We see too
19 many young kids ruining their lives with prescription drug
20 abuse." And several of the hospital administrators said,
21 "How can you do this for 10, 12, \$14.00 a day -- provide
22 counseling services, provide testing services, provide
23 diversion control services, provide medication for that?"
24 And, you know, people -- you know, this isn't the first
25 time I've been denigrated as a, you know, greedy business

1 person. And, you know, I encourage you to get to know me
2 or my facilities and I can only hope that you come to a
3 different conclusion. But, you know, I treat a number of
4 patients from this area in other clinics. I've heard
5 their stories. They have friends in this area who are not
6 getting treatment who want to get better, but right now
7 they're committing crime, they're at risk for overdosing.
8 They're using -- they're at higher risk for HIV and TB and
9 leaving their families, leaving their employment. And
10 thank you so much for your time tonight.

11 MR. FARBER: Thank you, Mr. Kester.

12 MR. LEACH: May I add something?

13 MR. FARBER: I'm sorry, sir, but we're past that point in the
14 public hearing.

15 MR. LEACH: I'd just like to answer some of his questions that
16 he brought up.

17 MR. FARBER: I'm sorry, but we're past that point in this
18 public hearing. We're at the closing. Maybe you could
19 speak with Mr. Kester afterwards. On behalf of the Health
20 Services and Development Agency, I want to thank you all
21 for attending this evening. I also want to remind you
22 that this application will be heard by the Health Services
23 and Development Agency on June 26th in Nashville and that
24 there will be an opportunity to present brief comments at
25 that time as well. This public hearing is adjourned.

1

Thank you all for attending this evening.

2

THIS CONCLUDES THE TRANSCRIPT OF THE
TRI-CITIES HOLDINGS, LLC d/b/a TREX TREATMENT CENTER
PUBLIC HEARING

BY: Rebecca Fink
Licensed Court Reporter

C E R T I F I C A T E

I, Rebecca Fink, Licensed Court Reporter and Notary Public for the State of Tennessee, do hereby certify that the foregoing is a true and complete *TRANSCRIPT OF THE PROCEEDINGS* of:

*TRI-CITIES HOLDINGS, LLC d/b/a TREX TREATMENT CENTER
PUBLIC HEARING*

as heard on May 28, 2013, the same transcribed to the best of my ability and understanding.

WITNESS my hand and official seal at my office in Kingsport (Sullivan County) Tennessee on this the 6th day of June, 2013.

Rebecca Fink
LICENSED COURT REPORTER
NOTARY PUBLIC
State of Tennessee

My Commission Expires:

November 10, 2013

CERTIFIED ONLY IF THE AFFIXED SEAL IS GREEN



STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
601 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243-0675

BILL HASLAM
GOVERNOR

E. DOUGLAS VARNEY
COMMISSIONER

MEMORANDUM

TO: Melanie Hill, Executive Director
Health Services and Development Agency

FROM: Sandra Braber-Grove, Director, Office of Contracts and Privacy / Assistant
General Counsel
TDMHSAS Division of General Counsel *Sandra Braber-Grove*

DATE: June 11, 2013

RE: Review and Analysis of Certificate of Need Application
Tri-Cities Holdings LLC d/b/a Trex Treatment Center - CN1303-005

Pursuant to and in accordance with Tennessee Code Annotated (TCA) § 68-11-1608 and Rules of the Health Services and Development Agency including the Criteria and Standards for Certificate of Need (2000 Edition, Tennessee's Health Guidelines for Growth, prepared by the Health Planning Commission) [hereinafter Guidelines for Growth], staff of the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), the licensing agency, have reviewed and analyzed the above-referenced application for a Certificate of Need.

Attached is the TDMHSAS report. At a minimum and as noted in TCA § 68-11-1608, the report provides:

- (1) Verification of application-submitted information;
- (2) Documentation or source for data;
- (3) A review of the applicant's participation or non-participation in Tennessee's Medicaid program, TennCare or its successor;
- (4) Analyses of the impact of a proposed project on the utilization of existing providers and the financial consequences to existing providers from any loss of utilization that would result from the proposed project;
- (5) Specific determinations as to whether a proposed project is consistent with the state health plan; and
- (6) Further studies and inquiries necessary to evaluate the application pursuant to the rules of the agency.

If there are any questions, please contact me at (615) 532-6520.

cc: E. Douglas Varney, Commissioner, TDMHSAS
Marie Williams, Deputy Commissioner, TDMHSAS
Dr. Jason Carter, Pharm. D., TDMHSAS, Chief Pharmacist and State Opioid Treatment Authority (SOTA)
Cynthia Clark Tyler, Director of Licensure, TDMHSAS

REVIEW AND ANALYSIS CERTIFICATE OF NEED APPLICATION # CN1303-005

Pursuant to and in accordance with Tennessee Code Annotated (TCA) § 68-11-1608 and Rules of the Health Services and Development Agency including the Criteria and Standards for Certificate of Need (2000 Edition, Tennessee's Health Guidelines for Growth, prepared by the Health Planning Commission) [hereinafter Guidelines for Growth], staff of the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), the licensing agency, have reviewed and analyzed the application for a Certificate of Need submitted by Mr. Steven W. Kester on behalf of Tri-Cities Holdings, LLC for the establishment of a new "outpatient opiate treatment program (OTP)" (also referred to as a "Non-Residential Substitution-Based Treatment Center for Opiate Addiction"; "Opioid Treatment Program" (OTP); or "methadone clinic"). The Applicant proposes to establish the facility at 4 Wesley Court in Johnson City, Washington County, Tennessee.

The report has three (3) parts:

- A. Summary of Project
- B. Conclusions
- C. Analysis - in three (3) parts:

<u>Need</u>	<u>Economic Feasibility</u>	<u>Contribution to the Orderly Development of Health Care</u>
<p>Evaluated by the following general factors:</p> <ul style="list-style-type: none"> a. Relationship to any existing applicable plans; b. Population to be served; c. Existing or Certified Services or Institutions; d. Reasonableness of the service area; e. Special needs of the service area population (particularly women, racial and ethnic minorities, and low-income groups); f. Comparison of utilization/ occupancy trends and services offered by other area providers; g. Extent to which Medicare, Medicaid, and medically indigent patients will be served; and h. Additional factors specified in the Tennessee's Health Guidelines for Growth publication for this type of facility. 	<p>Evaluated by the following general factors:</p> <ul style="list-style-type: none"> a. Whether adequate funds are available to complete the project; b. Reasonableness of costs; c. Anticipated revenue and the impact on existing patient charges; d. Participation in state/federal revenue programs; e. Alternatives considered; f. Availability of less costly or more effective alternative methods; and g. Additional factors specified in the Tennessee's Health Guidelines for Growth publication. 	<p>Evaluated by the following general factors:</p> <ul style="list-style-type: none"> a. Relationship to the existing health care system (i.e., transfer agreements, contractual agreements for health services, and affiliation of the project with health professional schools); b. Positive or negative effects attributed to duplication or competition; c. Availability and accessibility of human resources required; d. Quality of the project in relation to applicable governmental or professional standards; and e. Additional factors specified in the Tennessee's Health Guidelines for Growth publication.

A. SUMMARY OF PROJECT

Mr. Steven W. Kester (identified as the Managing Member or Manager) has submitted, on behalf of Tri-Cities Holdings, LLC d/b/a/ Trex Treatment Center (Applicant), an application for a Certificate of Need seeking the establishment of a new "outpatient opiate treatment program (OTP)" to be located at 4 Wesley Court in Johnson City, Washington County, Tennessee. An "outpatient opiate treatment program" is also referred to as a "Non-Residential Substitution-Based Treatment Center for Opiate Addiction"; "Opioid Treatment Program" (OTP); or "methadone clinic". On the Applicant Profile, for Type of Institution (Item 7.), the Applicant selected "Non-Residential Methadone Facility" (Item 7.N.). The purpose of review is "New Institution" (Item 8.A.).

The Applicant reports that its Manager is the co-founder and part-owner of nine (9) treatment programs, but information provided in the application [Supplemental #1, Page 4] names only seven (7): two (2) in the Asheville area (Crossroads Treatment Centers of Weaverville, NC and Asheville); three (3) more in Asheville (Western Carolina, CRC, and Mountain Area Recovery Center); and two (2) in Boone, NC (Stepping Stone and McLeod).

If the Certificate of Need application is approved and all other requirements are met, the facility would be licensed by the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). Information provided in the application indicates that it is anticipated that the facility will use buprenorphine, methadone, and abstinence-based treatment for "those suffering from opiate addiction." [Supplemental #1, Page 4] Applicant also reports that the facility will offer individual counseling services and group therapy to "help break the cycle of addiction and provide patients the life skills and resources to serve as productive members of their communities, families and employers." [Supplemental #1, Page 4] The Applicant reports that the commitment will be "to give patients their independence back as soon as medically, morally and ethically possible." [Supplemental #1, Page 4]

The Applicant reports that the proposed service area is the nine (9) most northeastern counties of Tennessee: Sullivan, Washington, Greene, Hamblen, Carter, Hawkins, Cocke, Unicoi, and Johnson, which reportedly covers 100% of the population of Tennessee's Methadone Service Area (MSA) #1, 97% of MSA #2, and 70% of MSA #3. The Applicant further reports that six hundred (600) patients from Northeast Tennessee travel to the Asheville facilities for services, and an admissions counselor at the Knoxville facility (owned by the Behavioral Health Group) indicated, in a phone call placed by the Applicant's Manager on February 25, 2013, that "nearly four hundred (400)" patients from Northeast Tennessee are served in their facility. [Supplemental #1, Page 4]

The Applicant reports that there is no major medical equipment involved in the project other than the dispensing devices used to correctly administer medication doses. The Applicant reports that the proposed building on the proposed site (at 4 Wesley Court) expected to be used for the facility requires no structural modifications, but will be

renovated as follows: the lobby will be re-purposed as a waiting room; large rooms will be partitioned to create offices for counselors, doctors, and the Executive Director; other large rooms will be partitioned and have plumbing added for use as examination and lab rooms; dosing rooms and associated dosing windows will be constructed; a room for the pharmacy and associated medicine vault will be constructed; a check-in booth will be constructed; and electrical, cabling, video, and telephony will be added in/for all rooms. [Supplemental #1, Page 6] The Applicant also reports that the total estimated project cost is \$670,000.00 which includes \$320,000.00 for facility costs [lease at an average of \$5,333.00 per month]; \$160,000.00 for preparation of site costs; \$80,000.00 for "operating loss carry" which was explained as the amount that needs to be financed during the time between when the facility opens until it becomes cashflow positive; and \$30,000.00 for legal, administrative, and consultant fees which the Applicant reported includes accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF). If the application is approved, the anticipated date construction (renovation; approved for occupancy) will be 100% complete is November 2013 with the issuance of a license occurring in January 2014 and the initiation of services occurring in February 2014.

B. CONCLUSIONS

As previously stated, if the application is approved and all other requirements are met, the facility would be licensed by the TDMHSAS. TDMHSAS staff have reviewed and analyzed the application and cannot support approval of the application because the majority of the Criteria and Standards for the type of facility being proposed in the application have not been met as explained below:

1. A note about specific criteria for a non-residential methadone facility. In addition to the other general criteria, the application for a Certificate of Need for a non-residential methadone facility should also address these and other specific criteria as listed in the Guidelines for Growth: 1) A non-residential methadone facility should provide adequate medical, counseling, vocational, educational, mental health assessment, and social services to patients enrolled in the program with the goal of the individual becoming free of opioid dependency; 2) Need should be based on information prepared by the Applicant which acknowledges the importance of considering the demand for services along with need as well as addressing and analyzing service problems; 3) The need assessment should also cover the proposed service area and include the utilization of existing service providers, scope of services provided, patient origin, and patient mix; 4) The Applicant should show that the geographic service area is reasonable and based on an optimal balance between population density and service proximity and show that the project is sensitive and responsive to the special needs of the service area in terms of accessibility to consumers, particularly women, racial and ethnic minorities, and low-income groups; and 5) The Applicant should show the project's relationship to policy as formulated in local and national plans, including need methodologies.

2. Need has not been clearly established as described in further detail in Section C.1. Overall, need has not been clearly established. The Applicant takes national projections and applies them to Tennessee and specifically Upper Northeast, Tennessee resulting in a misrepresentation of need. As mentioned in Section B.1., in addition to the general factors noted on Page 2 of this report, there are additional specific criteria for the type of facility proposed in the application under review. Many of the conclusions and inferences drawn by the Applicant from cited references are not scientifically based and national studies and statistics are mis-applied to the Upper Northeast, Tennessee area. The Applicant reports that the distance required to travel to treatment is a barrier to treatment and provides some statistics on distances from counties within the proposed service area to one of the existing clinics in Asheville, NC as well as the Knoxville, TN clinic. It is also reported that six hundred (600) patients from Northeast Tennessee travel to the Asheville, NC facilities for services, and an admissions counselor at the Knoxville, TN facility (owned by the Behavioral Health Group) indicated, in a phone call placed by the Applicant's Manager on February 25, 2013, that "nearly four hundred (400)" patients from Northeast Tennessee are served in their facility. [Supplemental #1, Page 4] The specifics of where in "Northeast Tennessee" these patients are located and, therefore, the distance they travel to Asheville, NC or Knoxville, TN is not provided by the Applicant, except that it is noted that the Knoxville, TN clinic is 104 miles from the proposed project location. Other data was submitted showing travel distances from Johnson City, Kingsport, and Bristol to Asheville, NC and Knoxville, TN; but the 1,000 patients reported to be receiving treatment in either the Asheville, NC or Knoxville, TN clinic have only been identified as being from "Northeast Tennessee", not these cities in particular, so it is not clear if the proposed project would improve driving distances for the reported existing patients. When discussing need in terms of where prescription pain medication abuse is the highest, the Applicant reports that the abuse of prescription pain medication is an epidemic in the United States and that the rate of abuse is higher in the proposed service area; however, as discussed in more detail in Section C.1., the study cited for this statement includes "Overall Conclusions" beginning on Page 226 of the study that report that "admission rates for the primary abuse of other opiates and synthetics [including hydrocodone, oxycodone, and any other drug with morphine-like effects except methadone] are higher in Appalachia than in the rest of the nation" [and] "in many ways, access to treatment is better in Appalachia when compared to the rest of the nation." The Applicant reports that there are "no existing SAMHSA-designated methadone maintenance treatment programs in [the] proposed service area"; therefore, there is a need. [Supplemental #1, Page 4] While it is true that there are no methadone clinics in the proposed service area, it is not true that there isn't access to medication assisted therapy and other forms of treatment in the proposed service area for those suffering from opioid addiction, as demonstrated in the list of providers submitted with the application. [Supplemental #1, Pages 99-103]

3. Economic Feasibility has possibly been established as described in further detail in Section C.2. The overall cost of the proposed project appears to be reasonable and, if the application is approved and all other requirements are met, the project should be able to be completed in a timely manner. The Applicant reports that the project will be funded personally by Mr. Steven W. Kester, identified as the "Managing Member of Applicant". It is reported that the monies are in reserve and have been committed to more than cover the project costs and start-up operating loss(es). In a March 15, 2013 letter from the Health Services and Development Agency (HSDA) to Applicant, Applicant is requested to submit a letter from a banking institution, Certified Public Accountant, etc. that demonstrates financial resources and/or reserves to implement the proposed project. In Supplemental #2 information, there is a facsimile from the Maxim Group indicating brokerage account balances of Mr. Steven W. Kester as of March 27, 2013. In a later letter from the HSDA to Applicant, the facsimile is noted, but there is another request for a letter from a banking institution, Certified Public Accountant, etc. that demonstrates financial resources and/or reserves to implement the proposed project. Staff of the TDMHSAS reviewing the application cannot find the requested documentation, but do take note of the statements in the application that the Applicant's Manager has sufficient resources in a brokerage account under his control for purposes of financially securing this project and that "all funds required to open and outfit this facility, and cover the operating loss during the first year, plus contingency, are secured." [Supplemental #1, Page 40] A review of the proposed charges for methadone at the facility causes concern to TDMHSAS licensure staff as discussed in Section C.2.
4. The project does not contribute to the orderly development of healthcare as described in further detail in Section C.3. The application under review is for a new facility. The Applicant, Tri-Cities Holdings, LLC d/b/a Trex Treatment Center, was organized pursuant to the Georgia Limited Liability Company Act on January 15, 2013 and was established to "engage solely for the formation of an opiate treatment program in the 'Tri-Cities' region of Tennessee and Virginia" [Supplemental #1, Page 75] Therefore, the Applicant has no prior experience in the operation of this type of facility or program other than the leadership and experience of its Manager who has "successfully opened nine (9) such facilities in four (4) states in five (5) years." [Supplemental #1, Page 5] When discussing transfer agreements, contractual agreements for health services, and affiliation of the project with health professional schools, since this is a new project, there are no existing agreements and affiliations, but the Applicant reports that it intends to have transfer relationships with all emergency hospitals in the Tri-Cities and surrounding area. Applicant also reports significant experience developing internships and other partnerships with local universities and professional societies, and looks forward to establishing these in the proposed service area. [Supplemental #1, Pages 42 and 44] As of the writing of this report, there are no letters of support from any of these entities in the proposed service area. When discussing staffing and the availability and accessibility of human resources required for the project, Applicant reports that it

recognizes the challenge of hiring and keeping the right staff and reports that all personnel will satisfy the TDMHSAS licensure rules, however, the staffing chart provided on Supplemental #1, Page 43 does not contain enough information to determine, at this time, if the staffing requirements will be met. For the criteria requesting documentation of deficiencies, if any, for existing licensed providers, and when the Applicant was requested to provide health survey results for the centers in North Carolina for which the Applicant's Manager claims "co-founder" and "part-owner" status, the response was that Applicant is a "shareholder of the company that operates these centers, but is not an officer or member of management ... [so] has no access to these records." [Supplemental #1, Page 45] Applicant verifies that it has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Substance Abuse Services, and/or any applicable Medicare requirements. In information provided in Supplemental #2 [Page 4 of a March 27, 2013 letter], Applicant also reports that TDMHSAS staff explained the licensing and Central Registry procedures for this type of program, however, the response to whether the Applicant will provide the HSDA and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required, the Applicant responded "Yes, subject to Federal HIPAA regulation." [Supplemental #1, Page 45] It is unclear whether Applicant is fully aware of and understands the complexity of all federal, Tennessee, and local laws, regulations, rules, and ordinances governing the establishment and operation of this type of facility and program. When asked about alternatives, the Applicant reported that more than fifty (50) locations in the Tri-Cities area were reviewed before selecting the proposed site of 4 Wesley Court. Further, the Applicant reported that the proposed site best meets the zoning requirements and was chosen because it is located in the biggest city of the proposed service area; is close to the maximum number of anticipated patients; has ready highway access to all points within the proposed service area; and requires only modifications to an existing structure, no new construction. [Supplemental #1, Page 41] The Applicant reports that it has "balanced cost control with providing patients quality care and a healing environment." [Supplemental #1, Page 41] In the March 15, 2013 letter from HSDA to Applicant, the Applicant was requested to provide a current letter from the City of Johnson City that the proposed site meets zoning requirements. Staff of the TDMHSAS reviewing the application cannot find the requested documentation, but do take note of statements in the application that the Applicant has requested zoning variances to accommodate this project. See Section C.3. for further discussion about zoning.

C. ANALYSIS

1. Need

Tri-Cities Holdings, LLC d/b/a/ Trex Treatment Center (Applicant) is seeking the establishment of a new "outpatient opiate treatment program (OTP)" to be located at 4

Wesley Court in Johnson City, Washington County, Tennessee. An "outpatient opiate treatment program" is also referred to as a "Non-Residential Substitution-Based Treatment Center for Opiate Addiction"; "Opioid Treatment Program" (OTP); or "methadone clinic").

Overall, need has not been clearly established. The Applicant takes national projections and applies them to Tennessee and specifically Upper Northeast, Tennessee resulting in a misrepresentation of need. Many of the conclusions and inferences drawn by the Applicant from cited references are not scientifically based and national studies and statistics are mis-applied to the Upper Northeast, Tennessee area.

When asked to provide the estimated number of persons, in the described area, addicted to heroin or other opioid drugs and an explanation of the basis for the estimate, the Applicant reports that there are approximately between 12,000 and 24,000 adults who are addicted to opiates in the proposed service area. The Applicant derived these from the following: the Substance Abuse and Mental Health Services Administration (SAMHSA) reports that "heroin use was 0.3% in 2011 and prescription pain medication abuse was 1.7% [therefore] combined, this would yield 12,000 opiate abusers or opiate dependents from the proposed service area." [Supplemental #1, Page 19] Further, the Applicant reports that the Tennessee Safety Subcabinet Working Group report [*Prescription Drug Abuse in Tennessee*] indicates that "almost 250,000 Tennesseans older than 12 reported abusing prescription opioids in 2009; Tennessee's population was approximately 6.3 million in 2009, yielding an incidence rate of 3.9%; this alone would yield approximately 23,800 opiate abusers or opiate dependents from the proposed service area." [Supplemental #1, Page 14] It is not clear how the Applicant arrived at its numbers. Further, the Applicant reports that an estimated number of 950 and 1,500 individuals from the proposed service area are in methadone treatment, relying on data from the methadone clinics in the Asheville, NC area, Knoxville, TN, and Boone, NC. [Supplemental #1, Pages 19-20] Due to a change in federal regulations, current Tennessee Methadone Central Registry data is not available. However, Applicant did provide calendar year 2008 data from the Tennessee Methadone Central Registry. [Supplemental #1, Pages 110B-110G] The Applicant incorrectly calculated that this data shows 8,889 Tennessee individuals receiving services at Tennessee methadone clinics. The Applicant did not deduct the number of individuals reported with a "county of residence" of 'unknown', nor did the Applicant deduct the number of individuals reported with a "county of residence" of 'out of state'. Using Applicant's figures of 8,889 and a state population at the time (2008) of 6,156,719, Applicant reports that there would be 866 patients in the proposed service area. [Supplemental #1, Page 19] Looking at the calendar year 2008 data and adding up the number of individuals with a "county of residence" of each of the nine (9) counties in the proposed service area, there are a total of 150 individuals from all nine (9) counties of the proposed service area, combined, reported to be receiving methadone treatment at the Knoxville, TN clinics. As mentioned, current data from the Tennessee Methadone Central Registry is not available, but it is not believed that there has been what amounts to a 2.5 times increase in the number of people from the counties in the proposed service area receiving services from a methadone clinic, which

is what would be needed to arrive at the Applicant's reported number of "nearly 400" patients receiving treatment at the Knoxville, TN clinic.

Need is also evaluated by the factors of special needs of the service area population, particularly women, racial and ethnic minorities, and low-income groups as well as the extent to which Medicare, Medicaid, and medically indigent patients will be served. Participation in Medicare and Medicaid is discussed in Section C.3. The Applicant states that a CDC report "clearly shows that opioid abuse and overdose cuts across genders, age groups, race, metropolitan status and economics [and] shows that Tennessee is among the 12 states with the highest per-capita overdose rates in the nation." [Supplemental #2, Page 22] A review of the cited reference [<http://www.fda.gov/downloads/Drugs/NewsEvents/UCM300859.pdf>] cannot confirm the Applicant's statements; the author of the cited reference states that "the findings and conclusions in this report are those of the author and do not represent the official position of the Centers for Disease Control and Prevention." Furthermore, states that are specifically covered in the presentation include Ohio, Utah, North Carolina, West Virginia, and New Mexico, not Tennessee.

The Applicant reports that the proposed service area is the nine (9) most northeastern counties of Tennessee: Sullivan, Washington, Greene, Hamblen, Carter, Hawkins, Cocke, Unicoi, and Johnson, which reportedly covers 100% of the population of Tennessee's Methadone Service Area (MSA) #1, 97% of MSA #2, and 70% of MSA #3. Applicant further reports that the MSAs were specifically addressed to balance population with proximity to care and notes that "[b]asically, where the State said there should be three facilities in 2002, there are none today, and the need has become materially more pronounced since that time." The Applicant does not cite a reference in support of this particular statement. [Supplemental #2, Page 22] A map of the MSAs was included with the application [Attachment C.3., Supplemental #1, Page 119], and while there are some pages that identify which counties are included in which MSA [Supplemental #1, Pages 120-121], there is nothing else to use to verify the Applicant's statement regarding the number of facilities expected to be located in each MSA.

Additional information provided in Supplemental #2 gives more detail about MSAs. It is noted that Tennessee Public Chapter 363 of the Acts of the 2001 General Assembly created Methadone Service Areas (MSAs) on the assumption that the closer one lives to a treatment program, the greater likelihood of participation. It is noted that the rate of participation is nearly twice as high for those living in or near a county that houses a methadone program (59.0/100,000) than the rate for those that live sixty (60) miles or more from a program (32.2/100,000). [Supplemental #2, Page 3 of the March 27, 2013 letter] Noted in the Tennessee Department of Health's report prepared as a response to Public Chapter 363 of the Acts of the 2001 General Assembly [<http://health.state.tn.us/Downloads/g6022004.pdf>], the State of Tennessee had a proposal to designate twenty-three (23) MSAs within the state to assure that all Tennesseans who wished to participate in a methadone maintenance treatment (MMT) program would have reasonable access to a program. An MSA, patterned in concept after the use of Rational Service Areas by the Department of Health in helping identify underserved health resource shortage areas in the state, is described as a "county or

constellation of contiguous counties in the state that comprise a sufficient general population making it likely that a minimum number of opiate dependent persons reside in the MSA who wish treatment and could support a program. This minimum population foundation was balanced with the need to establish geographic boundaries such that patients living within the MSA would reside within less than an hour drive one-way to a treatment program if the program were established in the heart of the MSA." [Page 8 of the report/response] The Applicant reports that it is estimated that 90% of the proposed service area's population is within sixty (60) miles of the proposed project location. [Supplemental #2, Page 3 of the March 27, 2013 letter] However, since the 1,000 patients reported by Applicant to be receiving treatment in either the Asheville, NC or Knoxville, TN clinic have only been identified as being from "Northeast Tennessee", it is not clear that Applicant's statements and conclusions support a need for the proposed project.

One of the other facts noted in the Department of Health's report/response is that businesses that establish programs require a general population of at least 100,000 persons from which to draw potential clients, generating 67 clients on average. [Page 6 of the report/response] The Applicant reports that six hundred (600) patients from Northeast Tennessee travel to the Asheville, NC facilities for services, and an admissions counselor at the Knoxville, TN facility (owned by the Behavioral Health Group) indicated, in a phone call placed by the Applicant's Manager on February 25, 2013, that "nearly four hundred (400)" patients from Northeast Tennessee are served in their facility. [Supplemental #1, Page 4] The specifics of where in "Northeast Tennessee" these patients are located have not been provided.

In other information provided by the Applicant describing the relationship of the proposed site to public transportation routes and general accessibility of the proposed site to potential patients, the Applicant reports that the proposed site is less than a quarter of a mile to transit stops on Johnson City's Transit System Blue Route and that the proposed location is less than one mile to I-26; a 20-minute drive from Kingsport, and a 22 mile drive from Bristol. The Applicant submitted a chart that shows it is 45 miles from Johnson City, TN to Weaverville, NC; 104 miles from Johnson City, TN to Knoxville, TN; and would be 0 miles from Johnson City to the proposed project location representing a "major improvement of the driving distances patients currently go for treatment". [Supplemental #1, Page 14] Similar data was submitted for patients living in Kingsport and Bristol; however, the 1,000 patients reported to be receiving treatment in either the Asheville, NC or Knoxville, TN clinic have only been identified as being from "Northeast Tennessee", not these particular cities. Elsewhere in the application, when discussing need in terms of barriers to treatment, particularly the distance to treatment, the Applicant reports that "of the barriers to access to healthcare, geographic distance is [at] the top of the list, even higher than access to healthcare insurance." [Supplement #1, Page 5] The TDMHSAS staff reviewing the application cannot verify this statement due to the cited reference being incomplete. The Applicant points out that a Johnson City, TN patient travels 200 miles round trip to Knoxville, TN and consumes approximately \$30.00 in gas and over three (3) hours of drive time, which is a hardship for patients, especially new patients who need to receive treatment seven (7) days per week. The Applicant further reports that "for every patient that makes the

commute, several are most likely foregoing treatment because they can't afford the time, money or energy." [Supplement #1, Page 5] It is interesting to note that the calendar year 2008 Tennessee Methadone Central Registry data shows only six (6) patients with a "county of residence" of 'Washington' receiving services at the Knoxville, TN clinics. The Applicant has not specifically identified any patients as being "Johnson City patients", but has only identified the 1,000 patients reported to be receiving treatment in either the Asheville, NC or Knoxville, TN clinic as being from "Northeast Tennessee"; therefore, it is not clear that Applicant's statement and conclusions support a need for the proposed project.

When discussing need in terms of where prescription pain medication abuse is the highest, the Applicant reports that the abuse of prescription pain medication is an epidemic in the United States and that the rate of abuse is higher in the proposed service area. However, the study cited by the Applicant for this statement [<http://www.kentucky.com/static/pdfs/ARCreport.pdf>] is from a May 2008 report by members of the National Opinion Research Center (NORC) at the University of Chicago and two members of East Tennessee State University presented to the Appalachian Regional Commission and is an analysis of disparities in mental health status and substance abuse prevalence, as well as access to treatment services in the entire 410 county Appalachian region comprising all or parts of thirteen (13) states, specifically all of West Virginia and parts of these twelve (12) states: Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, and Virginia. As noted in the study, the Appalachian region is home to more than 23 million people, extending from southern New York to northeast Mississippi and covers over 200,000 square miles of 410 counties in 13 states. The study does not specifically mention how many methadone clinics are in the Appalachian region, however, there are tables in the study that show that in 2005 there were a total of 891 substance abuse treatment facilities in the region with 16.59% of them providing Naltrexone; 8.24% of them providing methadone; 8.15% of them providing buprenorphine-Suboxone; and 5.10% of them providing Buprenorphine-Subutex (Pages 157-160). The study does not contain specifics on the locations of any of these facilities, so it is not clear that the results of this study can be appropriately applied to the proposed service area. It is interesting to note that in the "Overall Conclusions" statements of this study, beginning on Page 226, it is mentioned that "admission rates for the primary abuse of other opiates and synthetics [including hydrocodone, oxycodone, and any other drug with morphine-like effects except methadone] are higher in Appalachia than in the rest of the nation" [and] "in many ways, access to treatment is better in Appalachia when compared to the rest of the nation."

Last, but not least, when discussing the relationship of the proposed project to existing treatment in the proposed service area, the Applicant reports that there are "no existing SAMHSA-designated methadone maintenance treatment programs in [the] proposed service area"; therefore, there is a need. [Supplemental #1, Page 4] As stated previously, the Applicant takes national projections and applies them to Tennessee and specifically Upper Northeast, Tennessee resulting in a misrepresentation of need. Furthermore, many of the conclusions and inferences drawn by the Applicant from

cited references are not scientifically based and national studies and statistics are misapplied to the Upper Northeast, Tennessee area. While it is true that there are no methadone clinics in the proposed service area, it is not true that there isn't access to medication assisted therapy and other forms of treatment in the proposed service area for those suffering from opioid addiction, as demonstrated in the list of providers submitted with the application. [Supplemental #1, Pages 99-103]

2. Economic Feasibility

A review of the information supplied by the Applicant shows that there should be sufficient funds available for this project. The Applicant reports that the project will be funded personally by Mr. Steven W. Kester, identified as the "Managing Member of Applicant". It is reported that the monies are in reserve and have been committed to more than cover the project costs and start-up operating loss(es). In a March 15, 2013 letter from the Health Services and Development Agency (HSDA) to Applicant, Applicant is requested to submit a letter from a banking institution, Certified Public Accountant, etc. that demonstrates financial resources and/or reserves to implement the proposed project. In Supplemental #2 information, there is a facsimile from the Maxim Group indicating brokerage account balances of Mr. Steven W. Kester as of March 27, 2013. In a later letter from the HSDA to Applicant, the facsimile is noted, but there is another request for a letter from a banking institution, Certified Public Accountant, etc. that demonstrates financial resources and/or reserves to implement the proposed project. Staff of the TDMHSAS reviewing the application cannot find the requested documentation, but do take note of the statements in the application that the Applicant's Manager has sufficient resources in a brokerage account under his control for purposes of financially securing this project and that "all funds required to open and outfit this facility, and cover the operating loss during the first year, plus contingency, are secured." [Supplemental #1, Page 40]

This application under review is for the establishment of a new facility to be operated as a non-residential methadone facility [Item 7.N. in the Applicant Profile] Such a facility is also referred to as an "outpatient opiate treatment program"; a "Non-Residential Substitution-Based Treatment Center for Opiate Addiction"; "Opioid Treatment Program" (OTP); or "methadone clinic". The Applicant, Tri-Cities Holdings, LLC d/b/a Trex Treatment Center, was organized pursuant to the Georgia Limited Liability Company Act on January 15, 2013 and was established to "engage solely for the formation of an opiate treatment program in the 'Tri-Cities' region of Tennessee and Virginia" [Supplemental #1, Page 75] Therefore, the Applicant has no prior experience in the operation of this type of program other than the leadership and experience of its Manager who has "successfully opened nine (9) such facilities in four (4) states in five (5) years." [Supplemental #1, Page 5] Information provided in the application [Supplemental #1, Page 4] names seven (7) facilities: two (2) in the Asheville area (Crossroads Treatment Centers of Weaverville, NC and Asheville); three (3) more in Asheville (Western Carolina, CRC, and Mountain Area Recovery Center); and two (2) in Boone, NC (Stepping Stone and McLeod).

The Applicant reports that the total estimated project cost is \$670,000.00 which includes \$320,000.00 for facility costs [lease at an average of \$5,333.00 per month]; \$160,000.00 for preparation of site costs; \$80,000.00 for "operating loss carry" which was explained as the amount that needs to be financed during the time between when the facility opens until it becomes cashflow positive; and \$30,000.00 for legal, administrative, and consultant fees which the Applicant reported includes accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF). Applicant reports that the costs were developed with the Applicant's experience of having opened nine (9) such facilities in four (4) states and are "standard work elements" such as wall construction and moving walls; adding electrical, phones, cable and security; reconfiguring heating and air conditioning systems; adding workrooms unique to this type of facility (dosing windows, pharmacy, payment area, check-in area); outfitting the offices with desks, computers, and phones; and installing patient and accounting software systems unique to this type of facility. [Supplemental #1, Page 33] When asked to provide data for the Historical Data Chart for Net Operating Revenue, Net Operating Income (Loss), and other such information, for the last three (3) years for a center in Asheville, NC for which Applicant claims ownership, Applicant responded that as a shareholder of the company, not an officer or member of management, there is no access to this information. [Supplemental #1, Page 34]

The Applicant reports that there is no major medical equipment involved in the project other than the dispensing devices used to correctly administer medication doses. The Applicant reports that the proposed building on the proposed site (at 4 Wesley Court) expected to be used for the facility requires no structural modifications, but will be renovated as follows: the lobby will be re-purposed as a waiting room; large rooms will be partitioned to create offices for counselors, doctors, and the Executive Director; other large rooms will be partitioned and have plumbing added for use as examination and lab rooms; dosing rooms and associated dosing windows will be constructed; a room for the pharmacy and associated medicine vault will be constructed; a check-in booth will be constructed; and electrical, cabling, video, and telephony will be added in/for all rooms. [Supplemental #1, Page 6]

The Applicant reports that the proposed location is 4 Wesley Court, Johnson City, Washington County, Tennessee. The existing building is a free-standing building in what Applicant calls an industrial area, zoned for medical services, approximately 0.2 miles from the Quillen Rehabilitation Hospital. The Applicant acknowledges that Johnson City has "strict zoning requirements regarding locations of [methadone clinics]" [Supplemental #1, Page 10], but also reports that it spent significant time finding a location that best meets the zoning requirements and is well outside all limits that the city has imposed regarding schools, daycare facilities, parks, or locations that sell alcoholic beverages, as shown on a chart supplied with the application. [Supplemental #1, Page 12] It is important to note that the Zoning Code for Johnson City does permit "clinics" within the MS-1 Medical Services District [6.13.2.7], but defines a "clinic" as follows: "A building or portion of a building, other than a hospital, as herein defined, containing facilities providing outpatient medical, dental, chiropractic, optical, osteopathic diagnostic, and similar services, for humans, by physicians, dentists, and other health care specialists. The term clinic includes offices as a separate use for the

above, but does not include Substance Abuse Treatment Facility, or Methadone Treatment Clinic." [City of Johnson City Zoning Code] See Section C.3. for more discussion about zoning.

The proposed location is 1.66 acres and the square footage of the building is 8,260 square feet. Applicant reports that the facility has parking on all four (4) sides of the building, plus on an adjacent side lot and street parking is permitted. Applicant reports that the capacity of parking is sufficient to accommodate patients and, when asked to clarify if the space for the additional parking spaces is already owned by Applicant, the Applicant provided a chart showing the ratio of parking spaces to patients at the proposed facility in comparison to other similar facilities and reported that it is not believed that parking is an issue and no costs were reflected in the Projected Data Chart to remedy a parking problem. [Supplemental #2, Page 5] The proposed site is located on a cul-de-sac with industrial and commercial customers as neighbors. See Section C.3. for discussion on zoning with respect to being located on a cul-de-sac. The Applicant reports that traffic on the street is very light given the limited number [of businesses], hours of operations, and nature of the businesses. [Supplemental #1, Page 10]

The Applicant submitted a line-drawn floor plan showing the location of "counseling" rooms; "storage"; "break room"; "dosing rooms"; "exam room"; "pharmacy" [including vault]; the "check-in/payment" area; the "lobby/reception" area; and a "Group Room". The space marked "pharmacy" raises the question of whether the facility intends to have a pharmacy or if this room has been mis-labeled and is the 'medroom'. If the facility is to have a pharmacy, the Applicant must meet the requirements of the Tennessee Board of Pharmacy. There is also space marked for a "Director", but it is not clear if it is for the Program Director or the Medical Director. [Supplemental #1, Page 15] When asked about seating, Applicant reports that the lobby area could accommodate 153 seats and overflow seating, should it be needed, would be in the common area shown on the diagram.

On the Projected Data Chart [Supplemental #2a, Pages 30 and 31], the Applicant reports gross operating revenue from outpatient services, to an average of 530 patients in the first year of operation (expected to be 2014), of \$1,782,144.00. For the second year of operation (expected to be 2015), for services to an average of 1,056 patients, gross operating revenue is reported as \$3,903,715.00. Also reported are amounts for charity care of \$35,643.00 (Year 1) and \$78,074.00 (Year 2). Also reported are amounts for bad debt of \$17,821.00 (Year 1) and \$39,037.00 (Year 2). The resulting Net Operating Revenue is reported as \$1,728,680.00 (Year 1) and \$3,786,604.00 (Year 2). The chart shows deductions for operating expenses, other expenses, and capital expenditures of \$1,721,042.00 (Year 1) and \$3,221,026.00 (Year 2), resulting in a projected Net Operating Income of \$7,638.00 (Year 1) and \$565,578.00 (Year 2).

As previously stated, when asked to provide data for the Historical Data Chart for Net Operating Revenue, Net Operating Income (Loss), and other such information, for the last three (3) years for a center in Asheville, NC for which Applicant claims ownership, Applicant responded that as a shareholder of the company, not an officer or member of

management, there is no access to this information. [Supplemental #1, Page 34] Without this information, it cannot be determined if the reported projected numbers are in line with data from any of the other seven (7) facilities named in the application.

On Supplemental #1, Page 37, the Applicant reports a proposed charge of \$10.00 per day (\$70.00 per week) for methadone maintenance treatment at the proposed facility. The Applicant provided a comparison chart [Supplemental #1, Page 38] that shows charges at the proposed facility and those at some of the other facilities named in the application. The Applicant reports that since this is a new project there is no impact to previous charge schedules. The Applicant further reports that the proposed charge is 20%-33% less than charges at the nearest clinics in North Carolina and Tennessee. When asked for a further explanation, Applicant reports "tremendous benefit to lowering the barriers to treatment, and cost is a major factor; Applicant's Manager's other clinics in which he owns a partial interest, [have] tremendous results 'getting the word out' and breaking down barrier to treatment by offering treatment for \$1 per day for periods of six months to over a year." [Supplemental #2, Page 7] Elsewhere in the application, it is reported that the Applicant has reviewed and understands the licensure requirements of the TDMHSAS for this type of facility, however, the charge scheme proposed by the Applicant would be prohibited by the TDMHSAS licensure rules.

When asked about participation in Medicare and/or Medicaid, the Applicant responded that the project will not involve the treatment of TennCare participants and that certification will not be sought for Medicare and/or Medicaid. [Applicant Profile, Items 12 and 13, Supplemental #1, Page 3] Further, the Applicant reported that it plans to utilize self-pay programs and does not plan to participate in State and federal programs such as TennCare or Medicare because it "cannot justify the investment of resources required to maintain compliance with TennCare." [Supplemental #1, Page 40] Applicant did note, however, that a call to TennCare Solutions revealed that TennCare patients can be reimbursed for approved medication and services upon individual submission of receipts. When asked for further clarification, Applicant submitted additional information in Supplemental #2 and stated "Applicant will not offer any warranty or representation about TennCare coverage as to any item of service or medication [and] does not intend to make claims on behalf of any patient to TennCare." [Supplemental #2, Pages 2 and 3 of the March 27, 2013 letter] In the March 27, 2013 letter from HSDA to Applicant, it was mentioned that TennCare covers the drug buprenorphine for treatment of opiate addiction and that the medication, medical services, and transportation to providers are covered TennCare benefits. The Applicant was asked to clarify why it is not planning to accept TennCare for suboxone patients. Applicant responded that "the investment in personnel and systems, the on-going compliance and audit requirements, and the risk of penalties for non-compliance do not warrant the added revenue." [Supplemental #2, Page 1 of the March 27, 2013 letter] Further, the Applicant states that based on its experience, there are "additional risks associated with comingling TennCare patients with self-pay patients [such as] arguments, humiliation, etc. such that [it] is not worth implementing TennCare." [Supplemental #2, Page 1 of the March 27, 2013 letter]

When asked about availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal, the Applicant reported that there is "no treatment in the proposed service area [and that the proposal may appear to be more expensive than the status quo of no service, but] many organizations have documented [that] the cost of untreated persons significantly outweigh the cost of treatment, ..." [Supplemental #1, Page 40] The cited reference is the website of the TDMHSAS, but no particular document, article, or other source of this statement has been provided; therefore, the statement cannot be verified.

As for other alternatives regarding location and/or construction, the Applicant reported that more than fifty (50) locations in the Tri-Cities area were reviewed before selecting the proposed site of 4 Wesley Court. Further, the Applicant reported that the proposed site best meets the zoning requirements and was chosen because it is located in the biggest city of the proposed service area; is close to the maximum number of anticipated patients; has ready highway access to all points within the proposed service area; and requires only modifications to an existing structure, no new construction. [Supplemental #1, Page 41] See Section C.3. for discussion about zoning.

3. Contribution to the Orderly Development of Health Care

As stated elsewhere, the application under review is for a new facility. The Applicant, Tri-Cities Holdings, LLC d/b/a Trex Treatment Center, was organized pursuant to the Georgia Limited Liability Company Act on January 15, 2013 and was established to "engage solely for the formation of an opiate treatment program in the 'Tri-Cities' region of Tennessee and Virginia" [Supplemental #1, Page 75] Therefore, the Applicant has no prior experience in the operation of this type of facility or program other than the leadership and experience of its Manager who has "successfully opened nine (9) such facilities in four (4) states in five (5) years." [Supplemental #1, Page 5] When discussing transfer agreements, contractual agreements for health services, and affiliation of the project with health professional schools, since this is a new project, there are no existing agreements and affiliations, but the Applicant reports that it intends to have transfer relationships with all emergency hospitals in the Tri-Cities and surrounding area, including the Johnson City Medical Center and Wellmont Urgent Care (in Johnson City); Holston Valley Medical Center and Indian Path Primary Care (both in Kingsport); Bristol Regional; Union County Memorial (Erwin); Laughlin Memorial (Greeneville); and Hawkins County Memorial (Rogersville). Applicant also reports significant experience developing internships and other partnerships with local universities and professional societies, and looks forward to establishing these with East Tennessee State University's (ETSU's) undergraduate and graduate healthcare programs and Northeast State Community College's Social Work program. [Supplemental #1, Pages 42 and 44] As of the writing of this report, there are no letters of support or opposition from any of these entities; however, the documentation from the 2002 application for a proposed methadone clinic in Johnson City contains a letter of opposition from the then Dean of Medicine and Vice President for Health Affairs at the James H. Quillen College of Medicine at ETSU. The letter indicates that they did not participate in the "development of [the] proposal and do not support the opening of such a clinic in Johnson City." It is not known whether ETSU's position has changed.

When discussing staffing and the availability and accessibility of human resources required for the project, Applicant reports that it recognizes the challenge of hiring and

keeping the right staff and is "experienced and financed ready to meet the challenges." [Supplemental #1, Page 44] Further, Applicant verifies that it has reviewed and understands all licensing certification as required by the State of Tennessee for medical and clinical staff. When asked to clarify if a Program Director or Medical Director has been identified and to provide their names and background, Applicant responded that candidates have been interviewed and meet certification requirements, but due to the "uncertainty with respect to approval and timing, offers cannot be extended and candidates do not wish to be identified." [Supplemental #1, Page 43] When asked to clarify whether the Substance Abuse Counselors will be certified, the Applicant reports that all personnel will satisfy the State Minimum Program Requirements for Non-Residential Opioid Treatment Program Facilities, Staff Qualifications [Personnel and Staffing Requirements], Rule 0940-05-42-.29 [Supplemental #1, Page 43], however, the staffing chart provided on Supplemental #1, Page 43 does not contain enough information to determine, at this time, if the staffing requirements will be met and if staff will have the appropriate certifications. For instance, there is no mention of Physician Assistants or Advance Practice Nurses, no mention of a Program Physician, and no mention of which personnel will serve as Community Relations Coordinators. Applicant reports that a Security Guard is not planned, but if the need arises, a Security Guard will be hired. [Supplemental #1, Page 43]

For the criteria requesting documentation of deficiencies, if any, for existing licensed providers, the response is "not applicable". [Supplemental #1, Page 45] When requested to provide health survey results for the centers in North Carolina for which the Applicant's Manager claims "co-founder" and "part-owner" status, the response was that Applicant is a "shareholder of the company that operates these centers, but is not an officer or member of management ... [so] has no access to these records." [Supplemental #1, Page 45]

When discussing the understanding of standards and requirements, Applicant verifies that it has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Substance Abuse Services, and/or any applicable Medicare requirements. In information provided in Supplemental #2 [Page 4 of a March 27, 2013 letter], Applicant also reports that TDMHSAS staff explained the licensing and Central Registry procedures for this type of program, however, the response to whether the Applicant will provide the HSDA and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required, the Applicant responded "Yes, subject to Federal HIPAA regulation." [Supplemental #1, Page 45] It is unclear whether Applicant is fully aware of and understands the complexity of all federal, Tennessee, and local laws, regulations, rules, and ordinances governing the establishment and operation of this type of facility and program. It should be noted that the requirement to provide data for a Methadone Central Registry is a federal regulation and is also required by the TDMHSAS licensure rules, but has nothing to do with the HIPAA regulations.

When asked about alternatives, the Applicant reported that more than fifty (50) locations in the Tri-Cities area were reviewed before selecting the proposed site of 4 Wesley Court. Further, the Applicant reported that the proposed site best meets the zoning requirements and was chosen because it is located in the biggest city of the

proposed service area; is close to the maximum number of anticipated patients; has ready highway access to all points within the proposed service area; and requires only modifications to an existing structure, no new construction. [Supplemental #1, Page 41] The Applicant reports that it has "balanced cost control with providing patients quality care and a healing environment." [Supplemental #1, Page 41] As mentioned elsewhere, the proposed site is located on a cul-de-sac with industrial and commercial customers as neighbors. See Section C.3. for discussion on zoning with respect to being located on a cul-de-sac. The Applicant reports that traffic on the street is very light given the limited number [of businesses], hours of operations, and nature of the businesses. [Supplemental #1, Page 10] The Applicant was asked to provide, if possible, letters of support from the businesses that are located in the immediate area of the proposed location. Information provided in Supplemental #2 indicates that the other two (2) businesses located on Wesley Court are related to construction and the Applicant contacted the landlord/owner of one of the businesses and the individual "voiced no opposition" and the landlord of the Applicant's proposed site "knows the owner/landlord of the other business and has briefed that individual, and this individual has voice[d] no opposition to date. The Applicant would characterize their responses as neutral." [Supplemental #2, Page 4 of the March 27, 2013 letter]

As for the zoning requirements, in the March 15, 2013 letter from HSDA to Applicant, the Applicant was requested to provide a current letter from the City of Johnson City that the proposed site meets zoning requirements. Staff of the TDMHSAS reviewing the application cannot find the requested documentation, but do take note of statements in the application that the Applicant has requested zoning variances to accommodate this project. In Supplemental information, as requested, the Applicant provided a copy of the City of Johnson City zoning requirements [Supplemental #1, Pages 106-109]. As these zoning requirements show, the Board of Zoning Appeals is permitted to approve such a facility as a "special exception" only if the proposed facility complies with all five (5) criteria contained in Section 6.13.3.4 A.-F. As noted in other supplemental information, the proposed site for the facility is on a cul-de-sac, not an arterial street; therefore, does not comply with required criteria. Further, the proposed hours of operation are other than that required in the criteria. In Supplemental #2 information, the Applicant, when asked how it intends to address the zoning regulations, particularly the cul-de-sac versus arterial street and the proposed hours of operation, the response is that Applicant has requested a zoning variance from Johnson City. [Supplemental #2, Page 4] It should be noted that the Board of Zoning Appeals has no authority to grant a variance to special exceptions set forth in a Zoning Code, their role is to ascertain whether all criteria of a special exception have been met or not.

sbg
:sbg

Mathadone Clinic

Mark Farber
Tennessee Health Services and Development Agency
Frost Building
3rd Floor
161 Rosa Parks Blvd.
Nashville, TN 37243

2013 JUN 10 AM 9:21

Alan Cox, MD
630 Oneega Lane, A
Erwin, TN 37650

June 3, 2013

Mr. Farber,

I strongly oppose the plans for a Methadone/Suboxone clinic in Johnson City.

In my experience in practice and training, Suboxone and Methadone clinics are run by businessmen that have no interest or incentive for patients to ever come off narcotics, yes Suboxone and Methadone are a Opioid Narcotics. The patients come in weekly to get 'pill counted' and issued more narcotics, and charged for each visit, revenue for the owners. There are usually Locums Doctors that see the patients, again hired just to write the Narcotics then leave. I have seen very few patients ever come off Methadone/Suboxone.

This is just another form of legal narcotic distribution and Johnson City does not need this type of bussiness. Think of the opioid/narcotic patients that will be traveling to Johnson City for surrounding states and counties, not the type of tourists JC wants or needs.

Sincerely,

Alan Cox, MD



401 E. Main Street, Suite 3 • Johnson City, TN 37601 • (423) 232-0222 • fax (423) 232-0223
1729 Lynn Garden Drive • Kingsport, TN 37660 • (423) 288-0223 • fax (423) 288-0220
1627 Highway 11W • Bristol, TN 37620 • (423) 274-0100 • fax (423) 274-0104

2013 JUN 12 AM 9: 02

June 11, 2013

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

Re: Tri-Cities Holdings, LLC d/b/a Trex Treatment Centers
CN1303-005

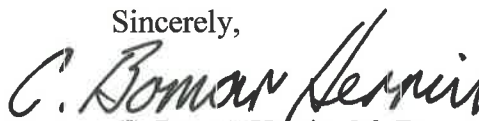
Dear Ms. Hill:

As the Certificate of Need for methadone use in Johnson City, TN is being considered, I will restrict my comments to clinical efficacy and safety.

I am Board certified in addiction medicine and have practiced in this field since 1984. Methadone, as a "full agonist," retains its Schedule II status. With the availability of Schedule III alternatives, I would encourage patients needing medication treatment of opioid dependency to avoid a drug more prone to overdose or respiratory depression. Page 72758 of Federal Register/Vol. 77, No. 235/Thursday, December 6, 2012 also notes that long-standing monitoring systems maintained by the FDA, SAMHSA and DEA indicate less abuse and diversion with buprenorphine than, "methadone and other Schedule II and Schedule III opioid drug products." The New England Journal of Medicine published findings that mothers treated with buprenorphine delivered babies with less neonatal abstinence syndrome than mothers treated with methadone.

Consistent with the adage, "first, do no harm," I continue to see methadone used less in favor of the alternatives now available.

Sincerely,


C. Bomar Herrin, M. D.

STITES & HARBISON^{PLLC}

ATTORNEYS

2013 JUN 10 PM 4:07
SunTrust Plaza
401 Commerce Street
Suite 800
Nashville, TN 37219
(615) 782-2200
(615) 782-2371 Fax
www.stites.com

June 10, 2013

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

Jerry W. Taylor
(615) 782-2228
(615) 742-0703 FAX
jerry.taylor@stites.com

RE: Tri Cities Holdings, LLC d/b/a Trex Treatment Center
CN1303-005

Dear Ms. Hill:

This letter of opposition is on behalf of the City of Johnson City, Tennessee. As you know, the site of the proposed noon-residential opiate treatment facility which is the subject of the certificate of need application is located within the city limits of Johnson City.

Johnson City maintains the project does not meet the requirements for the approval of a certificate of need. This clinic is not necessary to provided needed health care in the area, in that there are ample options for the effective treatment of opiate addiction existing in the Tri Cities and adjoining areas. The economics of the project are not in the public interest. According to the application, this would be a hugely profitable clinic, but no provision is made for indigent care or even for TennCare participation. For these reasons as well as others, the project likewise will not contribute to the orderly development of adequate and effective health care facilities or services. Therefore the certificate of need should be denied.

Representatives of Johnson City will be in attendance at the Agency's consideration of this application to explain these concerns in more detail.

Very truly yours,

STITES & HARBISON, PLLC



Jerry W. Taylor

June 10, 2013

2013 JUN 11 AM 8:43

Ms. Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243
(e-mail: Melanie.Hill@tn.gov)

**Re: Tri-Cities Holdings, LLC d/b/a Trex Treatment Center
CN1303-005**

Dear Ms. Hill:

I am writing to express my concerns about the establishment of a proposed methadone clinic by Tri-Cities Holdings [TCH] in Johnson City, a municipality within my congressional district and also my hometown.

First, as a physician (retired) and having practiced for more than thirty (30) years in the area of obstetrics and gynecology, the issue of addiction and pregnancy has always been a subject of deep concern to me. While I cannot claim any special talent or solution to the problem of opiate addiction in our country, I do know that an addiction can only be successfully addressed with an individualized plan, with physician oversight and compassionate care and counseling. I am also aware from my medical colleagues that, typically, especially with a pregnancy, buprenorphine has become the preferred choice for non-abstinence based addiction treatment instead of methadone. This is particularly true if the goal of the patient and his or her medical provider is to overcome the dependency.

Prior to running for Congress in 2008, I was privileged to serve as the Mayor of Johnson City. Johnson City's methadone ordinance was passed while I was serving as Chairman of the Johnson City Regional Planning Commission. I am offended by the claims asserted in a federal lawsuit filed by TCH against Johnson City claiming the ordinance was passed with discriminatory motive toward disabled individuals. One of the most basic considerations to the passage of the methadone clinic ordinance in Johnson City was a recognition that a professional, medically based methadone clinic, if such a need existed, should locate within the vicinity of other medical facilities.

For the last twenty years, Johnson City has promoted and encouraged what is locally referred to as the "med-tech corridor." The med-tech corridor is anchored on one end with East Tennessee State University and the Quillen College of Medicine, including the Veterans Administration Hospital. Adjacent to the Veterans Administration property and within the corridor, is Mountain States Regional Medical Center, a tertiary referral center and Level I Trauma Center. The vast majority of physician offices are located within the med-tech corridor along with a community hospital as well as a mental health hospital that includes inpatient chemical dependency services. There is also a surgical center for eye and orthopedic same day surgery service. The

northern end of the medical corridor is anchored with a "med-tech park" containing physician services and other facilities. TCH has elected not to propose locating within the medical corridor which is generally conducive to zoning for a methadone clinic.

I find the concerns of my constituents about traffic and parking at the proposed clinic location to be legitimate. Not only does the proposed location fail to meet the City's zoning code, it does not pass the test of common sense: a clinic purportedly designed to attract more than 1,000 people located on a dead-end street is guaranteed to create snarled traffic problems.

Thank you for allowing me the opportunity to express my concerns regarding the proposed methadone clinic. I would ask that the members of the Health Services Board provide a high level of scrutiny to this proposed clinic given the particular shortcomings I've outlined above.

Sincerely,


David P. Roe
Congressman

2013 MAR 21 AM 9:13

3-17-13.

This letter is to oppose
the proposed Methadone
Clinic for the Tri-Cities
of TN.

I feel that abstinence
based programs are the
best, not addition to
another drug. Thank you
Cora Bennett.



2013 JUN 11 AM 8:43

Strengthening our community through family preservation and restoration

June 10, 2013

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

Re: Tri-Cities Holdings, LLC d/b/a Trex Treatment Centers
CN1303-005

Dear Ms. Hill:

Families Free is a non-profit, faith-based organization dedicated to making positive impacts on families who are vulnerable, especially those who are affected by incarceration. We provide quality, evidence-based services combined with the faith-based principles of compassion, healing and restoration to promote positive lifestyle changes for our communities at-risk and often overlooked populations.

A large part of our agency's mission is to address the needs of women in Northeast Tennessee who are addicted to drugs. Drug addiction has far-reaching, often devastating, consequences on the individuals and their families trapped in this cycle. These individuals make decisions each day to put drugs above their own safety, health and freedom, as many become involved with the criminal justice system. Families Free meets many of these women through our services provided as a contracted provider of in-home services for the Department of Children's Services as well as programming offered under our licensure with the Department of Mental Health. On average, Families Free serves 250 individuals each month, of which a large percentage is affected by substance abuse.

As a licensed alcohol and drug and mental health treatment facility, Families Free follows guidelines of the TN Department of Mental Health and as a 501(c) 3 organization is overseen by a Board of Directors. Parenting education and support, anger management, case management, spiritual growth, employment skills, budgeting and other classes vital to a holistic treatment model are offered at our facility and in homes across the region. In addition to Families Free, Comprehensive Community Services ("CCS"), another licensed program, is located at 2514 Wesley Street, Johnson City. Families Free and CCS are both located within two miles of the proposed methadone clinic.



Northeast Tennessee is currently plagued with a significant substance abuse epidemic. This problem is being addressed by our agency, as well as other agencies in the area, however, the need continues to grow. In addition, our city currently has many doctors who are utilizing medication-assisted treatment protocols. Based on the history of Crossroads Treatment Centers in Ringgold, Georgia, Tri-Cities Holdings provides inadequate services to this vulnerable population. Tri-Cities Holdings operates under the guise of providing medication-assisted treatment, as a part of evidence-based therapy, however, exploits individuals through its use of methadone as a stand-alone treatment administered and monitored by personnel with insufficient education, experience and training.

Please consider this request to deny the certificate of need requested by Tri-Cities Holdings, as we believe that a holistic, therapeutic approach to treatment is much more beneficial to the individuals, children and families they represent in our community. Please contact me at (423) 773-9103 with any questions or to discuss this matter further.

Sincerely,

Lisa V. Tipton
Executive Director



Frontier Health®

1167 SPRATLIN PARK DRIVE
P.O. BOX 9054
GRAY, TN 37615
Phone: 423-467-3600
Fax: 423-467-3710
1-888-291-1935
www.frontierhealth.org

2013 JUN 10 AM 8:40

June 7, 2013

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

Re: Tri-Cities Holdings, LLC d/b/a Trex Treatment Center CN1303-005

Dear Ms. Hill,

This letter is written in **opposition** to the Certificate of Need application of Tri-Cities Holdings, LLC (CN1303-005).

Frontier Health is a regional behavioral health service in Northeast Tennessee. This agency provides services in mental health, substance abuse, and intellectual disabilities.

Services specific to individuals dealing with substance abuse include out-patient therapy, intensive outpatient services, medically monitored detox services, and residential treatment services (Magnolia Ridge) and residential services (Willow Ridge). Services are provided on a fee-for-service basis with grants, TennCare and private insurance reimbursement for some services. The agency maintains a "sliding fee scale" which allows adjustments to the fee depending upon the individual/family income. Frontier Health does not deny services based solely on the individual's inability to pay.

Frontier Health receives state grants and other support to assist individuals to receive care at Magnolia Ridge (detox/rehabilitation services), Intensive Outpatient, and Outpatient Services. Some individuals receive services which are totally grant funded.

The information above is being provided as a result of representations contained in a document made available from your office (Supplemental #1, Tri-Cities Holdings, LLC - CN1302-005 under the heading "Comparison of applicant's proposed services and inpatient treatment:". Cost of service at Frontier Health/Magnolia Ridge was reported as "\$6000 per month (compared to applicant's \$400/month outpatient)". This is not an accurate representation of the client's cost for services at Frontier Health. As indicated earlier, Magnolia Ridge services are supported by grants. Individuals may receive services at Magnolia Ridge at reduced rates and in some cases services are totally grant supported with no "out of pocket" cost to clients. Additionally, Magnolia Ridge is a residential service, which is very different from the proposed facility of Tri-Cities Holdings.

Other areas of concern:

- The Johnson City area has many physicians who prescribe Suboxone using a newer generation drug; as a result it appears that the service of opioid treatment is currently available in our region.
- Frontier Health has outpatient clinics available in each of the eight counties in Northeast Tennessee. This fact, along with the availability of other providers throughout the region, gives potential clients options choosing providers and options within a short driving distance.

Any argument presented implying the opposition to a methadone clinic is based on a premise to avoid/deny competition would be inaccurate, as Frontier Health provides abstinence based treatment services. Frontier Health has valued working relationships with many physicians in Upper East Tennessee who practice in the area of addiction treatment. A concern of Frontier Health is the concern of many others; the minimal involvement of physician participation in the business model submitted by the Tri-Cities Holdings.

Thank you for your consideration of the requested Certificate of Need by Tri-Cities Holding and I would urge the agency to deny the application. I plan to be present at the HSDA's consideration of this application on June 26th and will contribute my thoughts at that time.

Respectfully,



Charles E. Good
President and CEO

CG/tdm

Sent via email: Melanie.Hill@tn.gov
Mailed: Overnight by FedEx

Imagine re-living this
a day? Can you imagine
me?

with your methadone
patrons - please stay
in City, TN. You are only
one drug for another.

L Leach

March 18, 2006

Keep any and all methadone clinics
Johnson City, TN MAR 21 AM 9:12

I read Steve Koster's piece on why
City would benefit from having a
clinic. Here's my story.

8 on 7 years now, it has been, since
Eric was found dead by his Dad
he died May 21, 2006. He was 21 years
a junior in college and the love of our
was dating a nice girl. I thought life
was good. What I didn't know was he was
dealing with drugs. Addictive drugs. I didn't
realize until the end, that he was in so deep.
That kid so much but had no clue as to
of his life. Anyway, we lost Eric
on a Monday morning almost 7 years ago. His
autopsy certificate reads "methadone intoxication" as
death. Eric had gotten the methadone
"friend" who lived nearby. We found
it came in - small, plastic, with a bit
of liquid still left in the bottom. That's what
I son. The "friend" he got it from was
at the methadone clinic in Asheville, NC.
He was bringing the methadone to
it and selling it. This individual was
kicked. My son just died and that was that

FW: Letter of Intent for Methadone Clinic in Johnson City

Melanie Hill

Sent: Wednesday, March 06, 2013 1:19 PM

To: Kathleen Edwards; Melissa Bobbitt; Mark Farber; Phillip M. Earhart; Jim Christoffersen

Melanie

Melanie M. Hill, Executive Director

Health Services & Development Agency

melanie.hill@tn.gov

615-741-2364-phone

615-741-9884-fax

www.tn.gov/hsda

From: Melanie Hill

Sent: Wednesday, March 06, 2013 1:19 PM

To: Griff Adams

Subject: RE: Letter of Intent for Methadone Clinic in Johnson City

Thank you very much for your letter. I will share it with the members of the HSDA.

Melanie

Melanie M. Hill, Executive Director

Health Services & Development Agency

melanie.hill@tn.gov

615-741-2364-phone

615-741-9884-fax

www.tn.gov/hsda

From: Griff Adams [griffadams@icloud.com]

Sent: Wednesday, March 06, 2013 12:40 PM

To: Melanie Hill

Subject: Letter of Intent for Methadone Clinic in Johnson City

The Johnson City Press had an article about the proposed Methadone Clinic in Johnson City. We have in the past expressed our opposition to this type of facility and remain so. In my opinion this is just another drug but legal. The applicant agency indicates they make counseling available but it isn't required by their clients.

There should be a requirement for the clients to have one hour of counseling before receiving a refill on each RX. The purpose should be to get the client to a non dependent state on drugs. If the client is not completely drug free within 6 months, they should not be allowed to continue. People CAN live drug free. I am not opposed to treatment but it should have a goal of recovery, not another drug of choice.

Sent from my iPad

2013 MAR 15 AM 9:08

Janet Marrow
2223 Upper Stone Mtn. Rd.
Unicoi, TN 37692

Health Services and Development Agency:

I'm just one person, but I feel putting a Methadone Clinic in Johnson City would be bad for all the surrounding Counties. We already have a lot of traffic in Unicoi County - going to Asheville, N.C. - I feel traffic would be worse & also we've had numerous accidents where the people take the methadone & then drive home. There has to be a better treatment for "drug users". I think this is just a legal way for them to get their drugs. Some people I have known ^{have been} ~~that~~ "frequenting" methadone Clinics for years & have never weaned themselves off. Thank you for reading this."

Sincerely,

Janet Marrow
P.S. "We need to do everything we can to protect our youth from these drugs"

Mr. Farber,

I read in the Johnson City Press dated May 29, 2013 about the public hearing regarding a proposed Methadone Clinic in Johnson City, TN. I am very much opposed to these type clinics. I have had two close experiences with people who received care at Methadone Clinic.

My brother-in-law's longtime girlfriend, Penny, was involved in a car accident and had a crushed pelvis. She, over time, became addicted to her pain medications. Over the next few years, my family watched her sink slowly physically and mentally while on Methadone. On her last visit with us (they lived in GA), she was drowsy to the point that she would nod off during conversation. I asked her in private what medications she was taking. She admitted to Methadone as well as other medications you could buy on the street outside the clinic. I explained that I thought Methadone was a drug used to wean people OFF narcotics. She explained she had been prescribed a maximum dose for herself and as long as she could pay for that, she could receive that dosage on an ongoing basis. I expressed my concerns that she had a big problem and was scared for her wellbeing if she continued to take these drugs. She said she was afraid to come off the drugs because of withdrawals. My brother-in-law and Penny returned to GA on Monday morning. She was found dead on Thursday of an overdose. I believe it was accidental as she was folding laundry. I think she was in a vicious cycle and craved more and more. My family saw her go from a productive, kind and caring mother to someone unable to overcome her addiction but could easily feed it. The Methadone Clinic did not help her, in fact I feel it contributed to her demise. She didn't get assistance or encouragement to stop the drugs.

Several years ago, a young family with two school age children moved into our neighborhood. The father, Gary, "worked in Asheville, NC". It happened that this was a story told to cover his travel there to the Methadone Clinic. As time went on it became obvious that the dad had problems. He seemed impaired at random times. He asked several neighbors to borrow money or borrow a car(as he had several car accidents close together). He and his wife hosted several underage drinking parties when their kids were in high school. We witnessed the police pick their dad up on several occasions. He did not get better while receiving treatment over his years at the Methadone clinic. In fact, one morning, his children and wife got ready for school and work around him as he lay in the living room floor. He was already dead. It was not unusual for him to be passed out in the floor. At lunch, his wife came home and realized he was dead, and had been. The Methadone Clinic did not help Gary and his family. Once again, I believe it fed his problem. I believe many times it comes down to replacing illegal drug usage with a legal drug that is just as harmful, if not more so.

These are only my stories. My family witnessed both of these. How many more Methadone stories are there where people are enabled to feed unquenchable addictions? How many more families will be devastated?

I strongly oppose a Methadone Clinic in my community. I pray for more clinics whose goal is not to make money by supplying addictive drugs but to help people come off drugs. To provide ongoing support for these people to stay clean and productive, for their families and community.

Thank you for considering my input.

A handwritten signature in cursive script that reads "Janie Casey".

Janie Casey

106 Millstone Drive

Johnson City, TN

MAY 20, 2013

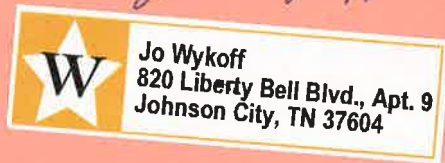
MR. FARBER -

2013 MAY 22 AM 9:03

I AM PLANNING TO ATTEND THE METHADONE
HEARING REGARDING A CLINIC IN
JOHNSON CITY. I HOPE THERE WILL
BE INFORMATION CONCERNING THE
RATIONAL OF TREATING ONE ADDICTION
WITH A POSSIBLY ADDICTING DRUG.

Jo T Wykoff

Jo J Wykoff



1725 W. Lakeview Dr.
Unit 7
Johnson City, TN 37601

2013 MAR 14 AM 9: March 12, 2013

Health Services and Development Agency
The Frost Building
3rd Floor
161 Rosa L. Parks Blvd.
Nashville, TN 37243

A company is asking the state to grant a certificate of need so that it may proceed with establishing a methadone clinic in Johnson City, TN. This is not a good idea for Johnson City and I feel it will create numerous problems.

A couple that lived next to my mother went to a methadone clinic in Asheville, NC. One week-end the male gave or sold his week-end supply of methadone to my nephew who consumed it all at once and died. There was a message on my nephew's phone where the male told my nephew not to tell his girlfriend about the bottle and he would pick it up. The police and the district attorney were shown this but nothing was done to the perpetrator. My mother thought they were selling their week-end supply and other drugs because of the number of cars that would come and only stay a few minutes. There was also another death the same week-end as my nephew for the same reason. Tragic stories like that would only in case if there were a clinic here. Please hold a public hearing on locating a methadone clinic in Johnson City.

Sincerely, Judy L. Kelly

I am writing about the
proposed methadone clinic
they are planning on opening on
Vesley St. or anywhere else in
Johnson City.

I know first hand this would
be a big mistake.

Most of the persons that visit these
clinics not only go there for
themselves - but for others
to whom they sell it to.

I have a nephew in Knoxville
who is a drug addict and
a lot of people buy and get
hooked on what others get
at these clinics.

This is only a legalized drug
clinic, causing more problems
than before.

Methadone Sch II drug under the
controlled substance act.

As we do not need a methadone
clinic in Johnson City; if anything
we need place for drug addicted
people with no insurance could go.
But really the only hope is the Lord!
(but no one wants or believes).

Master (Jesus) out of school
this is the result, God help us.

Thank you Martha
Gross

Doctor Assisted Recovery & Wellness Center, LLC

Michael D. Tino, MD, ABAM
100 W Unaka Ave, Suites, 3,4 & 5
Johnson City, TN 37604
423-928-1393

2013 JUN 11 AM 8:52

Melanie M. Hill, Executive Director
Tennessee Health Services & Development Agency
Frost Bldg, 3rd Floor
161 Rosa L Parks Blvd
Nashville, TN 37243

Re: Tri-Cities Holdings, LLC d/b/a Trex Treatment Center CN1303-005

Dear Melanie,

June 6, 2013

This letter is in regard to the need for Methadone treatment facility in Johnson City, TN.

As a Board certified Addictionologist, I feel the need to point out Johnson City, TN currently has opioid dependency treatment facilities that include hi level accountability.

Among those facilities, Doctors Assisted Recovery and Wellness, LLC offers medication assisted treatment for opioid dependent patients. Our program incorporates Evidence based medicine into medication assisted buprenorphine maintenance therapy. Our patients are assigned to a 12 step coach/ counselor at intake, as well as required attendance at a minimum of one per month of twice daily offered meetings in relapse prevention, addiction triggers, coping skills in recovery, and 12 step principles of recovery. Our program offers a male and female counselor/ coach, a requirement to submit to random urine toxicology screening, and random pill counts to assure accountability. We base each patients' therapy on weekly assessment at treatment team meetings. We offer referral for additional counseling and community agencies as the need arises. After 3 months of stabilization we also evaluate each patients need for endocrine / hormonal restoration as a result of addictions damage to body systems and to restore normal function. I would like to note that we have available openings for opioid dependent patients at any given time, therefore there is not an issue of no available treatment within our region of the proposed methadone clinic. With office based treatment such as ours, patients can be seen weekly, biweekly, or monthly with no need for daily clinic congestion, congregation, and daily patient visits which would occur with a methadone based treatment facility.

If I may be of further assistance, please do not hesitate to contact me at the above location.

Sincerely



Michael D. Tino, MD
Diplomate, American Board of Addiction Medicine



400 N. State of Franklin Road • Johnson City, TN 37604

2013 JUN 12 AM 9:02

423-431-6111

May 30, 2013

Mr. Pete Peterson
City Manager
City of Johnson City
601 East Main Street, P. O. Box 2150
Johnson City, TN 37605-2150

Re: Application of Tri-Cities Holdings, LLC d/b/a Trex Treatment Center for establishment of a methadone clinic in Johnson City

Dear Pete:

I am writing to you regarding the referenced application for the establishment of a methadone clinic in Johnson City and the concerns that have been expressed in the community about the project.

Mountain States Health Alliance ("MSHA") has always been a strong supporter of, and partner with, the City of Johnson City. Employing over 5,100 team members in Washington County alone, with a total annual economic impact to Washington County exceeding \$660,000,000, and creating over \$265,000,000 in annual payroll impact, MSHA is the largest employer in Johnson City. MSHA has a strong vested interest in the well being of Johnson City, the home of five of our hospital facilities, as well as of our corporate headquarters. As a community based organization that has always been highly supportive of community initiatives, we share the concerns about the methadone clinic project, and we support the City in its opposition to the project.

We appreciate this opportunity to confirm our support for the City in this matter, and please convey to the Board of Commissioners our gratitude for their work on behalf of the community.

Sincerely,

Dennis Vonderfecht
President/CEO

Cc: Erick Herrin ✓

Ralph Van Brocklin, D.D.S. Mayor

Allison Rogers

Tim Belisle

Dan Elrod

June 2, 2013

2013 JUN 10 AM 9:22

Tennessee Health Services and Development Agency
Frost Building – 3rd Floor
161 Rosa L. Parks Blvd.
Nashville, TN 37243

ATTN: Mark Farber

Dear Mr. Farber:

We are writing to express our dismay at the thought of a Methadone Clinic within the Johnson City limits. While there may be a need for a clinic of this nature, it does not need to be near schools, residential or commercial areas.

As citizens of Johnson City, we are concerned with the welfare of our children, the potential for increased crime, the probability of decreased property values and other unintended consequences that such a facility would bring to this area. Surely the rights of these citizens should not be negated by the placement of a Methadone Clinic. Such a clinic should be placed where there can be no harm or negative consequences to other inhabitants. We believe that such a clinic would decrease the desirability of living in this area and could potentially prevent commercial and economic growth.

We support Johnson City's zoning ordinances as it relates to the placement of a methadone clinic.

Sincerely, *We do not want this in our neighborhood*

Dea's Barber

Thelma Dellinger

Thelma Mills

Josephine West

Clara Denny

Marshall West

Sylvia Brown

Barbara Baum

Paula Bickel

Devon Maden

Betsy Long

Ruby Johnson

Proger E. Goodrich

Hellene Hawks

James Hawks



June 13, 2013

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

RE: Tri-Cities Holdings, LLC d/b/a Trex Treatment Center
CN 1303-005

Dear Ms. Hill:

As former Dean of the Quillen College of Medicine and more recently retired President of East Tennessee State University, I have remained observant of advances in the medical field with my affiliation with Mountain States Health Alliance, the Mountain Home Veterans Administration Medical Center, and the Quillen College of Medicine.

The recent proposal by Tri-Cities Holdings, LLC d/b/a Trex Treatment Center in Certificate of Need 1303-005 brings me some significant concerns:

- 1) The location proposed on Wesley Court in Johnson City is in a cul-de-sac with already high traffic flow and more particularly the daily ingress and egress of heavy equipment and trucks at the near-located Thomas Construction Company.
- 2) I have special concerns about a methadone clinic that by design operates with a minimal amount of physician time and involvement (one part-time physician that will be responsible for more than 1,000 patients a year) taking care of a special group of addiction patients that are very complex.
There is currently a very good and deliberate effort taking place in Johnson City regarding certification of doctors authorized to prescribe another drug, suboxone, and it is my understanding that there are advantages of treatment for opiate addiction using this drug instead of methadone. I am, therefore, concerned that a methadone clinic would impact negatively the current and better mainstreaming of opiate addiction treatment.

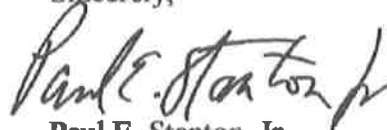
As one last thing, I have been supportive over the last twenty-eight years of faculty members with opiate addiction. I only want the best for a very complex condition in men and women and would recommend particularly that you look carefully at the proposal's staffing plan.

Page Two
Ms. Hill
June 13, 2013

While I believe that methadone is a legitimate drug, I ask you to question whether it is being used legitimately and properly.

Thank you for your consideration in this matter.

Sincerely,

A handwritten signature in cursive script, reading "Paul E. Stanton, Jr.", followed by a small flourish.

Paul E. Stanton, Jr.
President Emeritus

FW: METHADONE CLINIC JOHNSON CITY TN

Melanie Hill

Sent: Wednesday, March 06, 2013 12:26 PM**To:** Kathleen Edwards; Melissa Bobbitt; Mark Farber; Phillip M. Earhart; Jim Christoffersen*Melanie*

Melanie M. Hill, Executive Director
Health Services & Development Agency

melanie.hill@tn.gov

615-741-2364-phone

615-741-9884-fax

www.tn.gov/hsda

From: Melanie Hill**Sent:** Wednesday, March 06, 2013 9:49 AM**To:** RAYMOND PERKINSON**Subject:** Re: METHADONE CLINIC JOHNSON CITY TN

Mr. Perkinson,

Thank you for your letter. I will share your concerns with the members of the Health Services & Development Agency.

Melanie

Sent from my iPhone

On Mar 6, 2013, at 9:32 AM, "RAYMOND PERKINSON" <killer51a@embarqmail.com> wrote:

HAVING READ IN OUR PAPER WHERE STEVE KESTER OF TRI CITIES HOLDING LLC IS GOING TO TRY TO GET PERMIT FOR CLINIC IN JOHNSON CITY.I AM AGAINST THIS KIND OF CLINIC FOR MANY REASONS.ONE IS IT JUST A MAN MADE DOPE.IF WE HAVE AS HE SAYS WE HAVE 1000 A DAY FROM HERE GOING TO KNOXVILLE AND WEAVERVILLE NC. AS NASA WOULD SAY HOUSTON WE HAVE A PROBLEM.AS A TAXPAYER I AM TRIED OOF KEEPING A BUNCH OF DOPE HEADS IN THEIR SUPPLY.HALF GOING ON ON TENN CARE AND THE OTHER HALF ARE SELLING PART OF THEIRS IN ORDER TO LIVE.WHEN CALLED IN FOR A PILL COUNT ALL THEY DO IS BORROW FROM ANOTHER USER TO MAKE THE COUNT.THESE PEOPLE ARE DRIVING ON OUR HIGHWAYS MESSED UP.IF WE DONT GET HOLD OF OUR DRUG PROBLEM WE ARE IN FOR SOME REALLY BAD TIMES.CLINIC OWNERS COULD CARE LESS AS LONG AS THEIR PROFITS COME IN. THANK YOU RAYMOND PERKINSON 186 CLAUDE SIMMONS ROAD JOHNSON CITY TN 37604 PHONE 423-753-5929

2013 MAR 15 AM 9:09

Rev. Dan Wood
Pastor, Butler Baptist Church
PO Box 96
193 Piercetown Road
Butler, Tenn. 37640

Health Services and Development Agency
The Frost Building Third Floor
161 Rosa L. Parks Blvd.
Nashville, TN 37243

It has come to my attention that there is a company applying for a "Certificate of Need" to establish a Methadone clinic in Johnson City. As a Pastor in the area I stand opposed to any such establishment in Upper East Tennessee.

We certainly have big problems with drugs, but adding another source is not the answer. I do not see how giving opiate drugs to drug addicts will help get them off drugs. It seems to me that establishing such a clinic will only help certain people know the "who" and "where" of the drug users who might go to the "clinic". Is there evidence that any Methadone clinic cured anyone of drug abuse?

I believe there is an answer to drug abuse. The answer is changed lives. This only comes when people, be they drug users or not, realize that finding peace in their lives must come from a power outside ourselves. This means making a power outside yourself the "Boss" of your life. All the social and enforcement activities will fail outside of this one thing.

It is my hope that you will deny the application for a "Certificate of Need" for this or any other company wishing to set up a Methadone clinic in E. Tennessee.

Sincerely Yours,
Dan Wood
Pastor, Butler Baptist Church.

June 7, 2013

2013 JUN 11 AM 8:43

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

Re: Tri-Cities Holdings, LLC d/b/a Trex Treatment Centers
CN1303-005

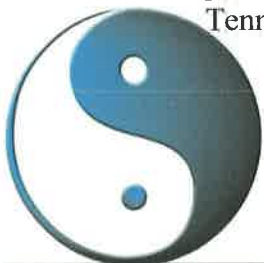
Dear Ms. Hill:

I am a board certified internist, the Associate Chief of Staff for Education at Mountain Home V.A. Medical Center, and an Associate Professor of Medicine in the Department of Internal Medicine at the Quillen College of Medicine at East Tennessee State University. In addition, I practice addiction treatment medicine, treating opiate-addicted pregnant women at the not-for-profit *High Point Clinic* in Johnson City, where I also serve as the Chairman of the Board of Directors.

More importantly, I am a recovering opiate addict, and have been drug free for 8 years and 11 months. As such I have first-hand experience, both professionally and personally, with the important issues involved in the certificate of need under consideration. This experience and knowledge are the bases for my opposition to this proposed non-residential opiate treatment facility.

Methadone treatment, if properly administered and medically supervised, can be a valid treatment component for opioid addicted individuals. The proposal as set forth in the CON application, however, is deficient in many respects and does not meet the criteria of need, economic feasibility and contribution to the orderly development of health care services and facilities.

I have attached a "Statement of Deficiencies" issued on November 28, 2012 related to a *Crossroads Treatment Center* in Georgia. The applicant's representative was the co-founder, Chief Financial Officer and Chief Operating Officer of *Crossroads Treatment Centers* and is a shareholder in the Crossroads organization. The deficiencies reflected in this report are the result of the inadequacies of the business model and operating protocols, which are also being presented by Tri-Cities Holdings to the HSDA in Tennessee for a Certificate of Need.



Evidence Based Addiction Medicine
A Not For Profit Corporation

High Point Clinic
Empowerment through Treatment

205 High Point Drive
Johnson City, TN 37601

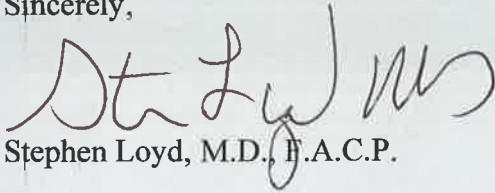
Changing the Treatment of those Addicted

Phone 423:631:0731
Fax 423:631:0732

Ms. Melanie Hill
June 5, 2013
Page 2

I urge the Agency to deny this application, and I plan on being at the HSDA's consideration of this application to contribute my thoughts. Thank you for your time and consideration.

Sincerely,



Stephen Loyd, M.D., F.A.C.P.



Evidence Based Addiction Medicine
A Not For Profit Corporation

High Point Clinic
Empowerment through Treatment

205 High Point Drive
Johnson City, TN 37601

Changing the Treatment of those Addicted

Phone 423:631:0731
Fax 423:631:0732

Statement of Deficiencies and Plan of Correction		Inspection begin date 11/28/2012 Inspection end date: 11/28/2012
Name of Provider or Supplier CROSSROADS TREATMENT CENTER OF NW GEORGIA I	Street Address, City, State Zip Code 4083 CLOUD SPRINGS ROAD RINGGOLD, GA 30736	
Inspection Results		
Z 0000 INITIAL COMMENTS		
<p>At the time of the survey, Crossroads Treatment Center of Northwest Georgia was not in compliance with Chapter 290-9-12, Rules and Regulations for Narcotic Treatment Programs, as a result of investigation #GA00119974. The allegations were substantiated. The following deficiencies were cited:</p> <p>.</p>		
Z 1014 290-9-12-.10(2)(e) STAFFING		
<p><i>Counselors. All counselors must be qualified by training, education, and experience to provide addiction-counseling services to persons who are addicted to narcotics and must be in compliance with Chapter 10A of Title 43 of the Official Code of Georgia Annotated.</i></p> <p>This Requirement is not met as evidenced by:</p> <p>Based on a review of employee records, policy and procedure, and staff interview, it was determined that the facility failed to ensure that 12 of 14 employed counselors (employees #10-#13 and #15-22), were qualified by training, education, and experience to provide addiction-counseling services.</p> <p>Findings :</p> <p>A review of employee records revealed that 12 of 14 appointed Substance Abuse Counselors were not certified or qualified by training and education to provide addiction-counseling services (employees #10-#13 and #15-22).</p> <p>A review of the facility policy titled, Job Description for Substance Abuse Counselor states, the Job Standard/Minimum Qualification is certified as a substance abuse counselor, or in the process of certification.</p> <p>An interview with the Clinical Director on 11/28/2012 at 11:30 a.m., confirmed the above findings. He/She stated, "Our program only has two licensed or certified counselors, I was not aware that</p>		

Statement of Deficiencies and Plan of Correction		Inspection begin date 11/28/2012 Inspection end date: 11/28/2012
Name of Provider or Supplier	Street Address, City, State Zip Code	
CROSSROADS TREATMENT CENTER OF NW GEORGIA I	4083 CLOUD SPRINGS ROAD RINGGOLD, GA 30736	
Inspection Results		
<p>you need certification in the State of Georgia. I thought a High School diploma was adequate, we hire our counselors and employ them as in training".</p> <p>A review of the facility's Intake Records for 4/1/12 to 11/28/12, revealed that a total of 351 clients were admitted to its program. The facility's current client census was 620. There were a total of 14 counselors on staff, and only two were qualified to provide addition-counseling services to clients.</p> <p>Z 1015 290-9-12-.10(2)(f) STAFFING</p> <p><i>Clinical Directors. All clinical directors must be licensed to practice medicine in the State of Georgia, licensed as a practitioner to provide treatment, therapeutic advice, or counseling for the rehabilitation of drug-dependent persons in compliance with state practice acts, or certified as an addiction counselor, must be at least 21 years of age, and must have at least one year of supervisory and administrative experience in the field of substance abuse treatment.</i></p> <p>This Requirement is not met as evidenced by:</p> <p>Based on review of employee records, policy and procedure, and staff interview, it was determined that the facility failed to ensure that one of one sampled Clinical Director (employee #3), had at least one year of supervisory and administrative experience in the field of substance abuse treatment, prior to employment.</p> <p>Finding:</p> <p>A review of the employee record for the Clinical Director (#3), revealed no evidence that he/she had one year of supervisory and administrative experience in the field of substance abuse treatment, prior to employment.</p> <p>A review of the facility's policy titled, Job Description for Clinical Supervisor, revealed that a minimum of one year clinical experience within the addiction field, was required, and one year of supervisory experience was preferred.</p> <p>An interview with the Clinical Director on 11/28/2012 at 10:30 a.m., confirmed that he/she did not have one year of supervisory experience prior to her promotion to the Clinical Director position. He/She stated, "I received my certification for Addiction Counselor in December of 2011, after</p>		

Statement of Deficiencies and Plan of Correction		Inspection begin date 11/28/2012 Inspection end date: 11/28/2012
Name of Provider or Supplier CROSSROADS TREATMENT CENTER OF NW GEORGIA I	Street Address, City, State Zip Code 4083 CLOUD SPRINGS ROAD RINGGOLD, GA 30736	
Inspection Results		
<p>that, I functioned as a Lead Counselor here for 8 months until I was promoted in September of 2012, to the Clinical Director position."</p> <p>Z 1302 290-9-12-.13(b) INDIVIDUAL TREATMENT PLAN</p> <p><i>In recognition of the varied medical needs of patients, the case history and individual treatment plans must be reviewed at least every 90 days for patients in treatment less than one year and at least annually for patient in treatment more that one year. This review will be conducted by the medical director or program physician along with the primary counselor and other appropriate members of the treatment team for general quality controls and evaluation of the appropriateness of continuing the form of treatment on an on-going basis. This review must also include an assessment of the current dosage and schedule and the rehabilitative progress of the patient, as part of determination of whether additional medical services are indicated. If such review results in a determination that additional or different medical services are indicated, the program must ensure that such services are made available to the patient and appropriate referrals for additional care are made.</i></p> <p>This Requirement is not met as evidenced by:</p> <p>Based on review of client records, policy and procedure, and staff interview, it was determined that the facility failed to ensure that a 90 day Individual Treatment Plan (ITP) was completed for 16 of 16 sampled clients admitted into the program for equal to or greater than 90 days.</p> <p>A review of client records #1-#16, revealed that there was no documentation of a 90 day ITP post admission, or any ongoing ITPs, to include a review of current dosage, schedule and the rehabilitative process of the patient.</p> <p>A review of the facility's policy and procedure manual revealed no evidence of a ITP policy appointed by governing body, to address 90 day treatment plan with medication dosage review for all clients.</p> <p>An interview with the Clinical Director on 11/28/2012 at 1:00 p.m., confirmed the above findings. He/She stated, "None of our clients receive a 90 day review of their medication dosage. We were not aware that a 90 day review was required."</p>		



P.O. BOX 4806 * JOHNSON CITY, TN 37602-4806 * (423) 282-3251 * FAX (423) 282-4916
WATER - SEWER - EXCAVATING - GRADING - ROAD BUILDING - BRIDGES

7 June 2013

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Frost Building, 3 rd floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

Re: Tri-Cities Holdings, LLC d/b/a Trex Treatment Center **CN1303-005**

Dear Melanie,

Please allow this letter with the accompanying attachments to be distributed to each of the board members of the Tennessee Health Services Board of Directors. I am writing in **strong opposition** to the request for a Certificate of Need to be issued to Tri-Cities Holdings, LLC to operate a Methadone Clinic at #4 Wesley Ct.

I will begin by introducing myself, my company, and our location as it relates to the proposed location of the Methadone Clinic at #4 Wesley Ct. in Johnson City Tn. My name is Gerald D. Thomas, and I am the President and sole owner of THOMAS CONSTRUCTION CO. INC. For the sake of brevity in this letter I will refer to my company as TCC. TCC is a Heavy Construction Firm that builds infrastructure including roads, bridges, new electric, communication, water, sewer lines, and site preparation for commercial, industrial, Federal, State and Local governments.. In support of these functions, TCC is also licensed and permitted to use and store explosives at #9 Wesley Ct. TCC is a Licensed Contractor by the State of TN, VA, and NC, and is also certified as a TDOT, VDOT, and NCDOT Contractor, and is a certified CCR Contractor for Federal Government Contracting. TCC street address is #9 Wesley Ct, and is located diagonally across the street from the proposed Methadone Clinic. TCC main office and shop are located here. I also own the eight (8) acres directly behind TCC and extending behind the adjoining property, occupied by CK Supply, to the end of Wesley Ct, and outlets through the cul-de-sac. This property is used primarily as a storage yard and staging point for construction materials, explosives, and equipment moving in and out for use on job sites. Also TCC trucks return via the cul-de-sac through this property to be washed at the end of each day and then are safety check and serviced before returning through the shop area to enter Wesley ct and on to Wesley St. Since the TCC Shop and maintenance facility is at 9 Wesley Ct, these trucks are in and our all day for needed repair and maintenance. I am also a one/third (1/3) partner in the property at #8 Wesley Ct directly across the street from the proposed clinic, and has been leased to CK Supply for the past 35 years(See the attachment 5 for property locations and TCC vehicle movement).

40 years ago my brother and I developed this small cul-de-sac property for Industrial use, primarily for TCC use, and had it zoned I-1. The intended use of this property was construction, industrial, wholesale suppliers, warehousing, and was **never** intended for high traffic use. The type of traffic you see here every day is large drywall haulers, tractor and trailers (frequently parked on the street when arriving late at night delivering drywall to CK Supply), TCC dump trucks moving in and out all day, and TCC heavy equipment haulers leaving early in the morning and in and out all day. TCC alone stages and maintains Seventy-five (75) heavy machines, twenty-seven (27) light duty trucks, and forty-six (46) heavy duty trucks and flatbeds from this site on 9 Wesley Ct. These equipment haulers are permitted by TN DOT for dimensions of 85 ft in length, 13.5 ft in width and 150,000 lbs of gross weight (**see attachment #6, annual permit**). I have also attached a couple of pictures (**attachment #1**) depicting the total width of Wesley Ct needed to turn out of our site and, also, the total width of Wesley St needed to turn out of Wesley Ct onto Wesley St. As you can see, it takes the entirety of both streets to get these haulers out, and there is no set schedule for these loads to move in out of our shop and storage yard as it depends on job requirements and the extent of equipment break-downs that dictate this schedule. It is very obvious these Equipment Haulers use all of the street, and added vehicular traffic would be extremely hazardous. You will also notice there are no sidewalks on either Wesley Ct or Wesley St, which is common in most industrial zones where pedestrian traffic is not anticipated and, therefore, sidewalks were not constructed on Wesley CT or Wesley St.

During the public hearing, Mr. Kester indicated there would be only twenty (20) cars per hour generated from the Methadone Clinic facility, but this seems inconsistent with the information provided the Health Services agency in his application and, besides, he provided no formula for such a twenty (20) car per hour calculation. Based on the staffing requirements reported in his application, during the first and last hour of operation, there will be that many cars just by his staff alone without getting into numbers of patients. (**see attachment #7 for staffing anticipated in the application**) Furthermore, in the "projected Data Chart" submitted as part of the application, he is projecting 530 patients per day for the first 45 days in 2014 and 1056 per day by 2015 (**see attachment # 2**). I am by no means a traffic specialist, but common sense tells me there is no way that 70-80 parking spaces can manage that kind of parking demand especially with the level of staff noted in the application. It becomes pretty obvious that **many** cars will have to be parked up and down Wesley Ct making movement of TCC, CK Supply, and Coastal Supply's heavy duty truck traffic near impossible and extremely dangerous to negotiate; this is a receipt for disaster.

Additionally, in his application to the Health Services Agency, Mr. Kester was ask the following: "The types of businesses that surround the proposed methadone project are noted. Are these businesses in support of the proposed project?" Mr. Kester's response was as follows: "there are two other businesses located on Wesley Court, CK Supply and Thomas Construction, both related to construction. Applicant contacted and briefed the land/owner of one of the businesses and this individual voiced no opposition. The landlord of the Applicant's proposed property knows the owner/landlord of the other business and has

Briefed that individual, and this individual has voiced no opposition to date. The Applicant would characterize their response as neutral." (See Attachment #3), It should have been noted in the application, there is a third (3rd) business located at the end of the cul-de-sac, Coastal Supply Company, and they were not mentioned in the application..

I want to go on record as the sole owner of at least 50% of the property accessing Wesley Ct, and a one-third (1/3) owner of the property occupied by CK Supply, and the lessee of the Joseph Thomas Property on Wesley St, as of the date of the application, March 28, 2013. I was **never** contacted, notified or even approached by either the Applicant or the Applicant's proposed Landlord about this Methadone Clinic being located at #4 Wesley Ct. I was not made aware of the proposed Methadone Clinic being proposed at #4 Wesley Ct until I read it in the Newspaper in late April of 2013. Furthermore, my brother and original partner in developing Wesley Park and the current owner of lots 2526 and 2526½ Wesley Street, which I currently lease, and a 1/3 partner in #8 Wesley Ct, occupied by CK Supply, to this day has not been contacted by either the Applicant or the Applicant's proposed landlord.

Finally, I would like to reiterate my strong opposition to locating this Methadone clinic at #4 Wesley Ct for the reasons I have stated above. If the traffic is even half what they are projecting, it will be a receipt for disaster exposing TCC to a high probability of accidents and possible injuries and fatalities resulting from mixing these dissimilar types of vehicles and pedestrians on this single outlet Industrial Cul-de-Sac. Inevitably, based on these traffic projections and the lack of parking and sidewalks, there will be pedestrians in the street, and with TCC large vehicles needing the entire street to negotiate in and out the probability of further injuries and fatalities increases dramatically. I would urge the Tennessee Health Services Board to reject this application for a Certificate of Need at least until they can find a suitable location on an arterial street with sidewalks that is designed to handle the volume of traffic they are projecting and does not mix dissimilar types of traffic, and not allow this facility to be located at a site that will expose TCC employees, and the clients and employees of the proposed facility, to unnecessary physical risks

Sincerely,



Gerald D. Thomas, President
THOMAS CONSTRUCTION CO. INC.

ATTACHMENT
1A



WESLEY CT
ENTRANCE

WESLEY ST
05.24.2013

ATTACHMENT
1A

ATTACHMENT
1 B

TRUCK ENTRANCE
#q wesley

WESLEY CT
05.24.2013

ATTACHMENT #2

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

	Year 2014 530 avg. pt	Year 2015 1,056 avg. pt
A. Utilization Data (Specify unit of measure)		
B. Revenue from Services to Patients		
1. Inpatient Services	\$ 1,782,144	\$ 3,903,715
2. Outpatient Services		
3. Emergency Services		
4. Other Operating Revenue (Specify)		
Gross Operating Revenue	\$ 1,782,144	\$ 3,903,715
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	\$ 0	\$ 0
2. Provision for Charity Care	35,643	78,074
3. Provisions for Bad Debt	17,821	39,037
Total Deductions	\$ 53,464	\$ 117,111
NET OPERATING REVENUE	\$ 1,728,680	\$ 3,786,604
D. Operating Expenses		
1. Salaries and Wages	\$ 780,000	\$ 1,573,135
2. Physician's Salaries and Wages	144,000	144,000
3. Supplies	579,750	767,972
4. Taxes	5,092	412,208
5. Depreciation	25,000	25,000
6. Rent	67,200	67,200
7. Interest, other than Capital		
8. Other Expenses (Specify) Utilities, insurance, trav	120,000	120,000
Total Operating Expenses	\$ 1,721,042	\$ 3,133,026
E. Other Revenue (Expenses) -- Net (Specify)	\$ 0	\$ 0
NET OPERATING INCOME (LOSS)	\$ 7,638	\$ 742,295
F. Capital Expenditures		
1. Retirement of Principal	\$	\$ 80,000
2. Interest		8,000
Total Capital Expenditures	\$	\$ 88,000
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	\$ 7,638	\$ 742,295

Attachment #3

March 27, 2013

Page 4

SUPPLEMENTAL- # 2

March 28, 2013

applicant's plans will interact with the DMHDD Methadone Authority's statewide plan. Did the applicant make contact, and if so, please discuss. **9:00 am**

Response: The Applicant talked to Mr. Ira Lacy on March 27, 2013. Mr. Lacy understands our position that the opiate abuse and addiction issues in northeast Tennessee warrant attention, and he confirmed there was no comparable treatment in the proposed service area to the treatment services we are proposing. Mr. Lacy explained the licensing and Central Registry procedures.

Further, Applicant's Managing Member had a substantive meeting on March 25, 2013 with the following representatives from the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS): Commissioner Doug Varney, Deputy Commissioner Marie Williams, Director of Licensure Cynthia Tyler, and Director of Legislation Kurt Hippel.

Applicant characterizes the meeting as very positive and potential grounds of agreement were as follows:

- The severe problems of opiate abuse in Tennessee and the proposed service area
- That no opiate treatment programs exist in the proposed service area and many adults drive great distances to get these treatment services in Asheville, Knoxville, Boone, NC and Galax, VA
- Distance is a barrier to treatment
- Applicant's Manager shared his history with proposed treatment services and the vision of TCH to implement these services in the proposed service area.

The scheduled hours of 5:00 AM until noon seven days per week is noted on page 98 of the application. However, on page 109 the Johnson City Zoning Regulations for methadone facilities states "the hours of operation shall be between 7:00 a.m. and 8:00 p.m." Please clarify.

Response: Applicant has requested a zoning variance from Johnson City to accommodate these hours.

Also, the Johnson City Zoning Regulations states, "the facility shall be located on and primary access shall be from an arterial street." How does the applicant intend to address this zoning regulation while the proposed site is located on a cul-de-sac?

Response: Applicant has requested Johnson City grant the Board of Zoning Appeals the authority to grant this arterial road variance. Applicant looked at over 50 sites within the Tri-Cities area and felt that the proposed site best met the needs of the community and patients relative to patient access, traffic, visibility, and distance from schools, daycare, parks.

The types of businesses that surround the proposed methadone project are noted. Are these businesses in support of the proposed project?

Response: There are two other businesses located on Wesley Court, CK Supply and Thomas Construction, both related to construction. Applicant contacted and briefed the landlord/owner of one of the business and this individual voiced no opposition. The landlord of Applicant's proposed property knows the owner/landlord of the other business and has briefed that individual, and this individual has voiced no opposition to date. The Applicant would characterize their responses as neutral.

Doctors who treat with Suboxone

TN cities over 50,000

Attachment # 4
information only

City	U.S. Census 2010 Population	# of Doctors within 30 mi.	Ratio of Doctor/Persons
Johnson City	63,153	52	1/ 1,214
Hendersonville	51,373	31	1/ 1,657
Franklin	62,487	31	1/ 2,016
Bartlett	54,613	20	1/ 2,731
Murfreesboro	108,755	33	1/ 3,296
Knoxville	178,874	21	1/ 8,518
Nashville	626,681	34	1/ 18,432
Chattanooga	167,674	9	1/ 18,630
Jackson	65,211	3	1/ 21,737
Clarksville	132,929	5	1/ 26,586
Memphis	646,889	20	1/ 32,344

Buncombe Co. NC

241,419

6

1/ 40,237

Pierce Land Surveying
 132 Isaac Lincoln Place
 P.O. Box 1442
 Elizabethton, TN 37644-1442
 (423) 542-4799 Office (423) 543-7911 Fax

PLAN	FILE	SCREEN FILE	SHEET
SN-002	0778	0778	1 / 1

LEGEND:

IRN - 1/2" IRON ROD NEW (SET)

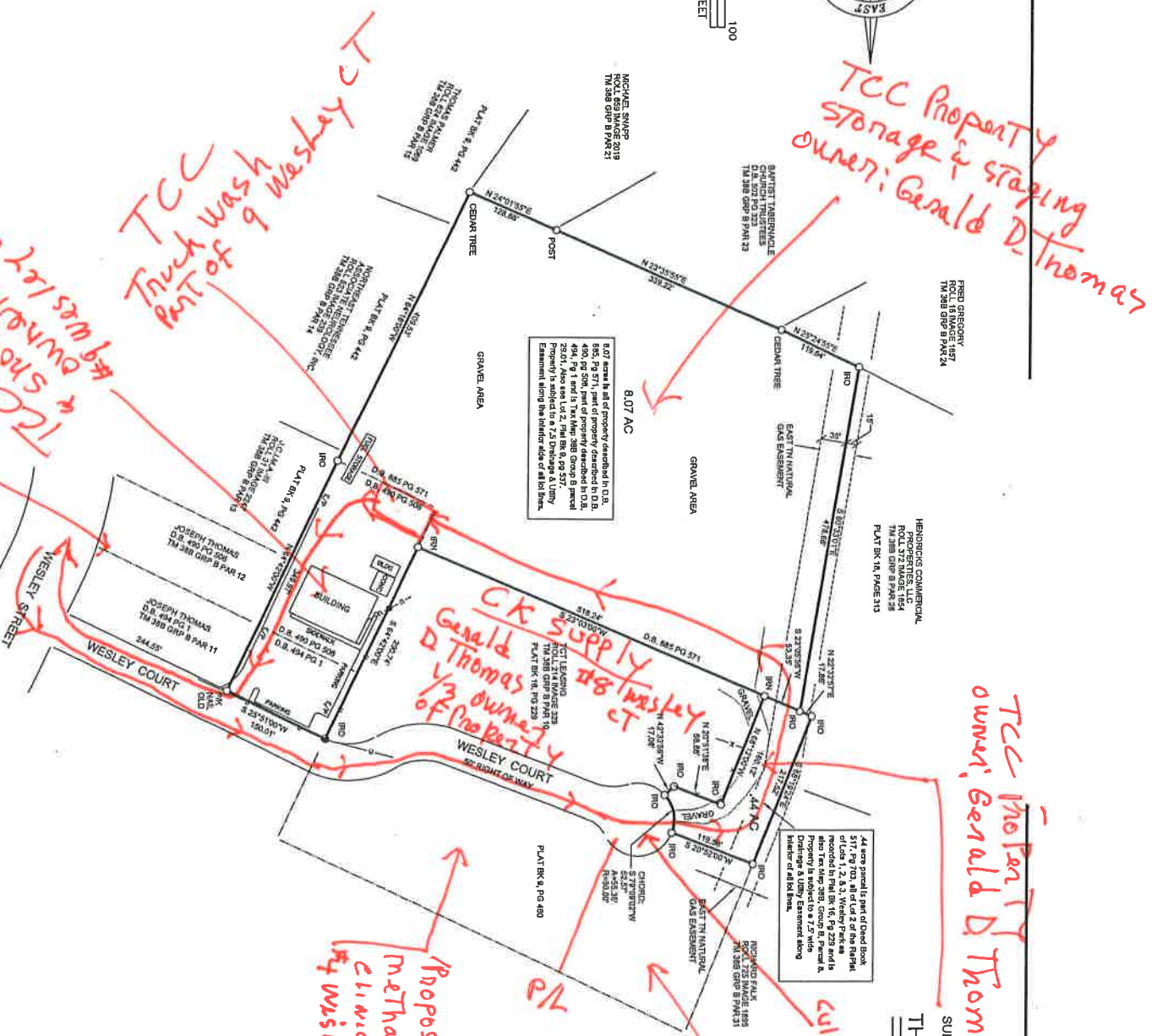
IRO - 1/2" IRON ROD OLD (FOUND)

—○— UTILITY POLE & OVERHEAD WIRES

SP - EDGE OF PAVEMENT

PLAT BOOK 16
PAGE 229

GRAPHIC SCALE - FEET
1" = 100'



TCC: John P. Thomas
owner, Gerald D. Thomas

SURVEY FOR

THOMAS CONSTRUCTION COMPANY, INC

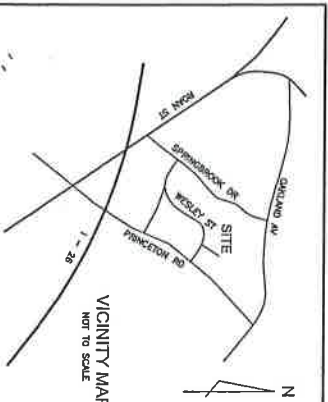
10TH CIVIL DISTRICT of WASHINGTON CO., TN
MAY 31, 2012 _____ SCALE: 1" = 100'

SCALE: 1" = 100'

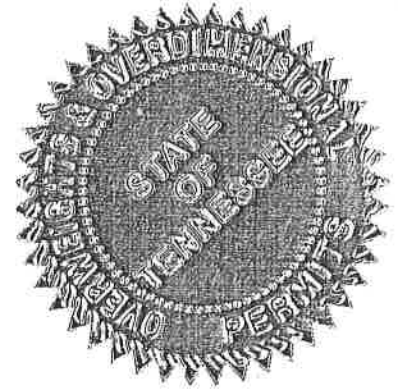
NOTES

- [illegible]

I hereby certify that this is a Category I Survey and the ratio of precision of the unaffiliated survey is 1:10,000 as shown herein and that this survey was done in compliance with current Tennessee Minimum Standards of practice.



Tennessee Department of Transportation
300 James K. Polk Building - 505 Deaderick St.
Nashville, Tennessee 37243-0331 - (615) 741-3821



ANNUAL PERMIT

Annual Permit Number: 20120712000251

Permit Fee: \$1,000.00

Permit Is Issued To: THOMAS CONSTRUCTION COMPANY, INC.

Address: P. O. BOX 4806
JOHNSON CITY, TN 37602-4806

Load: CONSTRUCTION EQUIPMENT
By truck and trailer, straight truck, or towing, or under own power.
Axle Limitation of 20,000lbs is NOT waived

Maximum Weight (lbs.): 150000

Width (ft-in): 13-6 **Length (ft-in):** 85-0 **Height (ft-in):** 13-10

Permit valid 07/23/2012 through 07/22/2013.
Sundays, Holidays, and Nights Excluded.

However, permits for overweight only shall be granted continuous movement.

Additional Restrictions:

Movements are allowed during daylight hours from sunrise on Monday through Saturday. However, movements fourteen (14') feet wide or eight-five (85') feet or greater in length will not be allowed within any statewide city limits, and all heavily adjoining commercial or residential areas between the hours of 7:00 a.m. to 9:00 a.m. and 4:00 p.m. to 6:00 p.m. (local time) from Monday through Friday because of traffic.

All crawler-type equipment to be loaded with the tracks parallel to center line of the trailer. Booms to be secured to prevent swinging. Bulldozers to be loaded with the blades to rear of trailer when the blade exceeds ten feet, six inches (10'6").

This permit is required to be issued by Tennessee Law. The permittee is hereby advised that information supplied herein is not necessarily accurate and is advisory only. Therefore, it is to be used at the sole risk of the permittee without warranty of accuracy. The recipient is classified as a bare licensee whose duty it is to assume the risk involved in using the roads herein designated.

In accepting this permit, the permittee acknowledges that the permittor is not a guarantor of the safe passage of vehicles. Accordingly, it is the positive duty of the permittee to measure all clearances of highway structures, both laterally and vertically, prior to the passage of the vehicle through their location.

Permittee is responsible for any damage to roadways, bridges, or to the travelling public.

Permit inoperative if road surfaces are affected by ice or snow.

Movement to be marked with signs and flagged in accordance with rules and regulations adopted by this department. All over width movements shall observe traffic conditions and shall, when traffic begins to accumulate behind the movement, pull off the road and allow traffic to pass. Failure to observe this highway courtesy shall be cause for the state enforcement officers to declare the permit void. *Not permissible for photo copies.*

Commissioner - Department of Transportation

DT-0008 Rev 08-96

ATTACHMENT 7

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED SUPPLEMENTAL- # 1

March 25, 2013
12:15pm

levels and compensation levels are shown in the table below³⁸, ranked in the order of the number of staff patient care positions. This data was aided by the Tennessee Department of Labor and Workforce Development, 2012 Occupation Wage Report for the Johnson City Healthcare Industry. The compensation figures below are in-line with the Tennessee statistics.

Position	Average number of fulltime staff, Year 1	Average number of fulltime staff, Year 2	Annual compensation Range, Entry - Senior	Tennessee Dept of Labor Range ³⁹
Substance Abuse Counselors	12	22	\$22,000 - \$30,000	\$25,661 - \$34,666
LPN Dosing Nurses	2	4	\$27,000 - \$37,000	\$27,512- \$37,268
Charge Nurse	1	1	\$45,000 - \$55,000	\$39,678- \$64,293
Charge Counselor	1	1	\$35,000 - \$40,000	\$31,651- \$34,646
Program Director	1	1	\$70,000 - \$110,000	\$78,220- \$99,889
Medical Director	Contract (part time)	Contract (part time)	\$150,000 - \$200,000	\$137,042- \$225,926

Total

18

30

A Security Guard is currently not planned. If the need arises, this position will be hired.

All personnel will satisfy State MINIMUM PROGRAM REQUIREMENTS FOR NON-RESIDENTIAL OPIOID TREATMENT PROGRAM FACILITIES, Staff Qualifications, Rule 0940-05-42-.29

Applicant has interviewed candidates for the Medical Director and a Program Director positions. Current candidates meet certification requirements. Because of the uncertainty with respect to approval and timing, offers cannot be extended and candidates do not wish to be identified.

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

The applicant operates nine other facilities in four states and is aware of the difficulty of hiring in the healthcare market.

³⁸ <http://www.tn.gov/labor-wfd/wages/2012/PAGE0144.HTM>

³⁹ TN Dept of Labor & Workforce Dev, Div Emp Sec, R&S.

and then 12 AM 8:12

Dear Health Service and Development Agency,

Please do not leave a
certificate of need for a methadone
clinic in Johnson City, Tennessee.
we do not need more addicts here.
methadone is just swapping one
addiction for another.

Sincerely,
William J. Cone, M.D.

4-4-2013

2013 APR 12 AM 9:11

Dear Sir or Ma'am,

Thank you for sacrificing your extremely valuable time to read my letter. I am a 30 year old, lifelong citizen of Johnson City, Tennessee. I have seen street opiates and prescription opiates alike ruin lives and kill our young and old alike. I know, not think, that some of these tragedies could have been prevented by our supporting a methadone clinic in Johnson City.

The people in this area are so apprehensive because they don't know the facts about methadone. Methadone has been used for over sixty years to treat the disease of addiction successfully.

There is an epidemic in our region and it isn't going to go away without our help. Most of the people in this region exploit this untruth, they say they don't want to attract addicts to this area with a methadone clinic but over 1,000 citizens of the Tri-Cities travel to North Carolina, Knoxville, Chattanooga to a methadone clinic daily. This is ridiculous and dangerous. The addicts are here, they are our neighbors, our friends, sons and daughters and they need our help!

Please do not let misinformation and stigma dictate what should be done in this dire situation. The Certificate of Need is the first step to help for those who are afflicted.

Please make sure that the bias opinions of the people who are against opening a methadone clinic in Johnson City, Tennessee will not mandate what medical treatment a person can gain access to. This is a medical treatment and should be available to all who are in need. Please don't let the populous practice medicine without a license.

Thank you for your precious time. Please look at the facts and not listen to the ill-informed opinions. Please grant the Certificate of Need for this life transforming treatment in Johnson City, Tennessee.

Very truly yours,

Catherine Simerly

Catesimerly@yahoo.com

A handwritten signature in black ink, appearing to read 'Catherine Simerly', with a stylized flourish at the end.

Thank you

To Whom it may concern,

2013 JUN 12 AM 9:01

My name is Charles Love. I have been in favor of a methadone clinic in Johnson City for quite a while. I have seen nothing but positive things come from these programs. I am a resident of Carter County. My address is:

Charles Love
126. W. 4th Riverview Ave.
Watanga, TN 37694

I would love to see a clinic in Johnson City. I think it would greatly diminish the pain pill problem and save lives in the process. Please consider this as I know first hand who's benefiting and who would have their lives changed for the better.

All the Best,
C Love

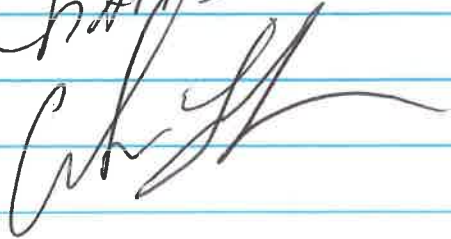
Dear Sirs,

2013 MAR 22 AM 9:20

I strongly support having a methadone clinic in Johnson City, It's true that most people assume you're talking about Crystal Meth. The two are as different as black and white.

In the past 2 years I've had 3 friends commit suicide because of lack of having treatment, We have places for alcoholism and mental illness, we need to help those addicted to opiates,

There are way more crimes committed by people trying to support their habit than those trying to get help.

Charles Johnson


Friday, May 24, 2013

Tennessee State Health Services and Development Agency
Melanie M. Hill, Executive Director
melanie.hill@tn.gov

To Whom it may concern:

It has come to the attention of many advocates and medication assisted recovery patients that letters of support are being accepted and reviewed regarding the opening and operation of the proposed Methadone Maintenance Treatment Facility in Johnson City, TN

As an advocate and patient of Medication Assisted Recovery myself I cannot stress enough the importance of such a clinic. For years I suffered from the disease of addiction trying many times on my own and with the help of medical detox to try and abstain from the use of opiates. Not until my experience of a methadone clinic located in the state of Alabama did I have any success. I last entered into recovery with the help of Methadone Maintenance on July 2002. I have since left the clinic but have been able to remain in recovery for the last 11 years.

Had it not been for the utilization of Methadone I would hate to see where my life would be now, today. Being able to manage my addiction to opiates clearly saved my life. I do hope that you will seriously consider the opening of the clinic if not to save just one more life.

Sincerely,
Dee Black
Advocate for Medication Assisted Recovery
N.E.A.R/ Northeast Addiction Recovery

Tennessee Health Services And Development Agency
Melanie M. Hill, Executive Director
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243

2013 MAR 21 AM 9:14

March 11, 2013

Ms. Hill:

I am writing you in support of Tri-Cities Holding's Certificate of Need for an opiate treatment program in Johnson City, Tennessee.

I have the unique advantage of treating over 1,000 opiate-addicted patients both in an opiate treatment program and a private physician's office. I have medically supervised methadone, buprenorphine and abstinence-based services to treat those suffering from opiate addiction. I have no financial interest in Tri-Cities Holdings, nor am I a part of the staff or management.

There are several points I wish your Agency to know about treating those suffering from opiate addiction.

1. Physician-based practices that offer buprenorphine treatment are significantly disadvantaged relative to opiate treatment programs:
 - a. These offices rarely provide counseling services, which are a critical component to treatment and a patient's ultimate path to independence
 - b. Private doctor's office don't have the same requirements for drug testing, attendance and group therapy that are critical to ensure compliance and a patient's commitment
 - c. The hours of operation of a doctor's office do not meet a patient's need to balance work and family commitments
 - d. Addicts are co-mingled with the other patients in the office which creates shame and discomfort
 - e. Staff at opiate treatment programs (nurses, counselors, doctors, etc.) are specifically trained and credentialed to treat the specific needs of those suffering from opiate addiction
 - f. When compared to the cost and services of an opiate treatment program, doctors' offices are significantly over-priced
2. Johnson City is trading the perceived problems of a methadone clinic with the very real costs of opiate addiction. Distance plays a significant role in treatment. In my Atlanta-based practices, I frequently see patients who travel great distances because the community they live in does not want a clinic or is too small to support a clinic. As you know, patients who are just entering treatment must come every day. This is the precise time that they are most vulnerable to relapse, and this distance places a tremendous burden on them.

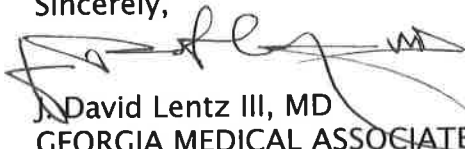
Further, for every patient that travels far for treatment, he or she will tell you they know 2 or 3 addicts that want treatment, but cannot make the commitment of time or money associated with a long daily commute.

Untreated addicts commit crime to support their habit, leave their families, get incarcerated, and clog emergency rooms. In keeping a clinic out, Johnson City is inviting in many more problems.

3. Whatever the perceived problems of opiate treatment programs, Johnson City has exported them to the nearest communities that will support treatment. Does this seem like the right thing to do?
4. The perceived problems of opiate treatment programs are just that, perceived. There are nearly 1,300 of these clinics in the US. If they were as bad as the Johnson City officials have made them out to be, do you think they would be tolerated? The fact is, these clinics open and operate with a whimper, not a bang. The worst problems are parking and smoking, which pale in comparison to theft, prostitution, HIV, and broken families.
5. Most of the opposition that I have read is from uninformed people who perpetuate myths. Have you heard from former patients, staff or neighboring businesses? Asheville has five of these clinics, yet it's a wonderful city.
6. Speaking of myths, here are some doozies: "Methadone is just trading one drug for another. Addicts should just go cold turkey." Less than 10% of opiate addicts can withdraw "cold turkey" without relapse. Many pain pills are just as addictive as heroin and substantial research has shown that abstinence-based withdraw is far less successful than medication-based treatment.
7. Johnson City's problems may get worse. "Pain mills" and other diversion operations are being successfully identified and shut down. That's the good news. However, if pain pills addicts have no treatment, they will likely turn to heroin, which has become cheaper and easier to obtain in most communities.

I encourage you to take an objective review of the facts. Doing so will lead you to the decision that this project is best for the community.

Sincerely,



David Lentz III, MD
GEORGIA MEDICAL ASSOCIATES PC
2121 Fountain Drive
Suite A
Snellville, GA 30078



BankTennessee
Welcome Home!

June 12, 2013

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Boulevard
Nashville, TN 37243 (e-mail: Melanie.Hill@tn.gov)

Re: The Farms at Bailey Station CN 1308-008

Dear Ms. Hill:

The following is written in support of the certificate of need application of The Farms at Bailey Station in Collierville, Tennessee.

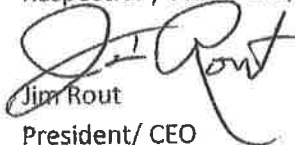
I have witnessed the dynamic growth of Collierville since my first term on the Shelby County Commission in 1978. During my four (4) term or sixteen (16) years on the Shelby County Commission Collierville grew from a small rural community into a bustling municipality. In 1994 when I took office as Shelby County Mayor, Collierville was rapidly becoming one of the fastest growing communities in Tennessee. During my two (2) terms as Mayor, Collierville grew at an unprecedented pace.

With that growth has come the need for residential and health care options that The Farms at Bailey Station will provide. The independent living units, townhomes, and garden homes will offer our seniors a variety of residential choices. As health issues arise and maturity changes the needs of the residents it will be a seamless transition to assisted living, skilled nursing or memory care when and if that need occurs.

As a Commissioner I heard the promises made to the community when Kirby Pines was being discussed 30 years ago. Without question the promises were kept. Many seniors have received comfort and care that did not exist at the level provided by Kirby Pines and their management company, Retirement Companies of America, prior to their opening in the 1980's.

I encourage the Agency to look upon this outstanding proposed project and its excellent track record by a favorable consideration of this certificate of need application.

Respectfully submitted;


Jim Rout
President/ CEO

5/9/2013
Jim Shannon
114 Shannon Lane
Johnson City, Tennessee 37601

Dear Sir or Ma'am,

I am writing to you today pleading with you to grant the Certificate of Need for a methadone clinic in Johnson City, Tennessee. I fully support the placement of a clinic in my hometown.

I have a daughter and son-in-law who both have to travel three hours each day they go to their clinic through dangerous mountain roads. I feel it is ridiculous that they have to travel so far for this life saving medical treatment.

I have seen dramatic changes for the better in both my daughter and son-in-law. My daughter works full time and is able to help take care of me. I had a stroke a few years ago and need some help. My son-in-law is a full time college student and has a 4.0 GPA. I have never seen them so happy and productive.

I have no doubt that this evidence-based medical treatment will help hundreds in our area that need and want help. Addiction is a disease and addiction is an epidemic in our region.

Please do not let the opinions of uninformed individuals rationalize the wrong decision. We would be doing our community a huge disservice to deny them this treatment. There is a better life waiting for every addict and if they need this recovery plan to help them succeed then we need to provide it for them.

Thank you for your time,
Jim Shannon

Joy Jackson

PO Box 185

Chuckey, TN 37641

March 18, 2013

2013 MAR 21 AM 9:14

Health Services and Development

Agency

The Frost Bldg. Third Floor

161 Rosa L. Parks Blvd.

Nashville, TN 37243

To Whom It May Concern:

As a citizen of Upper East Tennessee, I am writing in support of approval of a certificate of need for a methadone clinic in Johnson City.

Prescription drug and opiate addiction has become rampant in our area and is reflected in increased criminal activity, unemployment and the breakup of families.

No addict started out with the thought that he/she could become physically dependent on these drugs. No one wants to be a junkie. Many want to quit but do not know where to turn. A treatment clinic in our area could help many hundreds of addicts turn their lives around and once again be productive members of our society. They would be able to work and lead a normal life close to home. As it is now, addicts from the Tri-cities area must drive to Knoxville or Asheville, NC every day for treatment, which is nearly impossible while trying to hold down a job. Many will give up because of this limitation.

A methadone clinic in Johnson City would be a positive thing for this community and all of its citizens.

Thank you,



Joy Jackson

To Whom This May Concern,

2013 MAR 20 AM 9:07

My name is Kathy Ostertag, RN and I am writing in support of the Certificate of Need for an opiate treatment program (OTP) in Johnson City. I have no financial interest in the company trying to open the OTP.

I have worked at three OTPs in the Asheville, North Carolina area. In all three clinics, many of the patients come from the Tri Cities area and drive great distances, crossing the state line to get treatment. I believe that for every patient that made the trek, 2 or 3 did not. Distance and time are the leading barriers to getting treatment. You should worry about these people who don't get treatment. Statistically, 80% of addicts support their addiction through crime - theft, prostitution, forgery, etc.

Let me give you an example of a typical day in the life of a person/family in recovery who has made the brave choice to get help for their addiction: A young family living in the Johnson City area - one maybe both parents have struggled for years with addiction - but now they have hope - they have a place where they can get relief from the physical pain of addiction and the support of a staff of Nurses, Doctors, and highly qualified counselors to help them in this brave effort. Finally without the chain of addiction and the lifestyle that goes along with it - the father and mother now both have legitimate jobs are able to provide their families with a good and safe home - gained back the respect they had long ago lost for themselves. The one draw back is it is over an hour away on often dangerous roads in inclement weather. - So their day starts out with an alarm that rings at about 1:00 AM - they get up, get their kids up from a good nights sleep, place their sleeping children in the car for the long drive to Asheville - an hour or more away - arriving at about 3:00 AM at the treatment program to wait for the clinic to open at 5:00 AM - they arrive so early to ensure a place at the front of the line, as there are so many others their that have made the same long trip from your area that day - to facilitate getting back home earlier. They enter the clinic, they usually see their counselor, get their medication and usually several times a month have a urine drug screen - all of this taking at least an hour. Now they drive back home arriving there around 7:00 AM - and now there day begins - just like yours and mine. They get ready for work - get the kids' fed and ready for school and/or day care - leave the house to have a productive day just like the rest of us. Except this family has already had a full day. Now multiply this by 1000 people/families in treatment - This facility is NEEDED.

Ask yourselves is it fair that the residents of the Johnson City area should have to endure such hardship in order to gain their lives back. These are members of our community that you and I work with everyday - side by side - families just like yours and mine - wanting a better life for themselves and their children - should it be so hard for them - ask yourself that. I can't tell you how many times I have heard the words "Kathy - This place has saved my life". As a health care professional I can tell you there is nothing better, or more rewarding to know that you have helped to improve the lives of others - this program will change lives in your community.

For those who do make the drive, many, like the family I describe above, are under great stress struggling with the finances and time to make the commute. Many drop out of treatment because they can't afford the gas, or have work or family commitments that conflict. Dropping out of treatment often means relapsing back to drugs.

Companies want to open in the Tri Cities area because there is a desperate need. I understand locals are concerned about crime and property values. I can tell you first hand after 12 years working in addiction treatment - these facilities are good neighbors - going unnoticed in their locations - supporting outreach programs in the community with education and support of community programs - these substance abuse treatment programs SAVE lives and FAMILIES and in turn help SAVE our communities. Many studies have shown that the far greater risk is the LACK of treatment.

Approve the CON. Lower crime. Lower drug use. Less disease. Compassionate care.

Sincerely,

A handwritten signature in cursive script, appearing to read "Kathy Ostertag".

Kathy Ostertag, RN

To Whom it May Concern:

I agree with treating Drug addiction
in Johnson City, TN or any where in TN
so those addicted can be helped. It's no

different than having Cancer or any other medical
problem and being denied treatment. I think the
state should educate the population about those
clinics & etc. Right now ignorance is the
education.

Jesia C. Snalling
P.O. Box 8
306 W. 5th Ave
Watauga, TN. 37694

Thank You,
Jesia Snalling

Phone: 423-631-7112

I am in favor of a Methadone Clinic
in Johnson City

Michael Shane Lyle II
4522 Rocky Branch Rd.
Walland, TN 37886 2013 APR 23 PM 12: 21
(865) 242-7582
BallroomShane@gmail.com

April 15, 2013

State of Tennessee
Health Services and Development Agency
The Frost Building Third Floor
161 Rosa L. Parks Blvd.
Nashville, TN 37243

To Whom It May Concern:

I am writing this letter in *SUPPORT* of the proposed opioid addiction treatment clinic/ methadone maintenance treatment center/clinic in Johnson City, Tennessee, and I urge you to approve the opening of the clinic forthwith and support its opening.

Methadone Maintenance Treatment (MMT) is one of the MOST evidence-based treatments in ALL of medicine, and I, personally, would likely not be alive today if not for this life-saving and life-restoring treatment. I was blessed to live in the metro-Knoxville area and have a MMT clinic within a reasonable distance when I was in a cycle of desperation due to active, chronic opioid addiction to prescription pain killers. I began a MMT program and quickly began to regain my life. After several years I began a medical tapering, and I have since been able to live 100% opioid-free working full time, paying taxes & otherwise contributing to the good of our state and society. (NOTE: Depending on the severity of damage done to the endogenous opioid receptor/natural endorphin system in the brain during active addiction the time opioid addicted patients may need to stay in treatment varies greatly from patient to patient with many needing it long term, for 10-20 years, and some needing methadone treatment indefinitely. Time in treatment should be determined by a physician with an addiction specialty alone & not by statute or law.) I AM PROOF that Methadone Maintenance Treatment WORKS and SAVES LIVES.

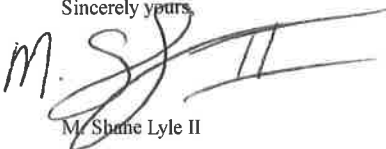
Multiple studies show distance is a primary obstacle to treatment, so requiring Johnson City/Tri-cities area residents to drive such enormous distances (the closest in-state clinic is currently in Knoxville, TN) to seek treatment results in many just giving up and going back to pill mills, illegal drug dealers & heroin. Also, study after study shows that MMT clinics raise employment rates, improve family lives and lower crime rates. A 2012 University of Maryland Medical School study found that there was NO geographical correlation between MMT clinics and criminal activity; Quite the opposite, actually, as drug-related crime has been shown to decrease in communities when MMT clinics open.

Lastly, it is important to note that people who are addicted to opiates and are seeking treatment are sick (opioid addiction is a chronic, treatable medical condition) and are protected under the Americans with Disabilities Act and the Rehabilitation Act of 1973. Denying disabled people convenient access to treatment, and forcing them to drive hundreds (in this case thousands) of miles for treatment is a violation of federal law.

I encourage you, as a Tennessee citizen, taxpayer & registered voter, to approve the opening of the MMT clinic in Johnson City, Tennessee forthwith and to support its opening.

Thank you for your consideration.

Sincerely yours,


M. Shane Lyle II

National Alliance for Medication Assisted Recovery, Inc.

435 Second Avenue New York, NY 10010
phone/Fax (212) 595-nama

oxanne Baker, C.M.A. President

oard of Directors

onna Schoen, C.M.A. First Vice President

erry Wolf, R.N., C.M.A., Vice President

R. Neuberger, C.M.A. Secretary

renda Davis, B.S., CASAC-T

laude Hopkins, C.A.D.C., C.M.A. Grievance Coordinator

hrlis Kelly, Advocates for Recovery through Medicine

anette C. Wollfarth, C.M.A. Chapter Coordinator

May 31, 2013

dministration

ycelyn Woods, M.A., C.M.A. Executive Director

alter Ginter, C.M.A. Training & Recovery Services

oby Rakosi Goulter, WSM&B Forum

rrman Joseph, Ph.D., C.M.A., Ambassador At Large

Health Services and Development Agency
The Frost Building Third Floor
161 Rosa L. Parks Blvd.
Nashville, TN 37243

dvlsory Board

idrew Byrne, M.D.

ncent P. Dole, M.D.†

ivld A. Fiellin, M.D.

rrman Joseph, Ph.D., C.M.A.

ffrey D. Kamlet, M.D., FASAM, DABAM

zabeth Khuri, M.D.

son Kletter, Ph.D.

yce H. Lowinson, M.D.

dith Martin, M.D.

hn J. McCarthy, M.D.

ura McNicholas, M.D., Ph.D.

bert G. Newman, M.D.

Thomas Payte, M.D., C.M.A.

ny J. Primm, M.D.

rc Shinderman, M.D.

To whom it may concern:

This letter is in support of the Opioid Treatment Program for Johnson City, TN.

Methadone maintenance treatment and more recently buprenorphine has been thoroughly researched and carefully evaluated for almost six decades. It has received more scientific scrutiny and evaluation than any other medical treatment or human service program. While studies began in the United States nearly every industrial country has implemented medication assisted treatment (MAT i.e. methadone and buprenorphine) and repeated the original studies. Most evaluations have shown that, when correctly implemented, the treatment is capable of producing remarkable improvements in patients who were previously dysfunctional heroin addicts. MAT patients throughout the world have been restored to productive lives, relations with families and children have been reestablished, many have furthered their educations, obtained employment and improved their physical and mental health. Nevertheless, contrary to scientific evidence, methadone maintenance treatment remains a controversial issue among substance abuse treatment providers, public officials and policy makers, the public at large and the medical profession itself.

MAT when prescribed as a maintenance medication functions as a normalizer for a deranged physiology and

Continued

Affiliated Groups and Chapters

A NAMA Recovery, NAMA Recovery NorCAL

C Organizing Network, CT NAMA Recovery

S CT NAMA Recovery, Delaware NAMA Recovery

F NAMA Recovery, Atlanta NAMA-R (Suboxone)

G If Coast NAMA, Chicago NAMA Recovery, The MAG IND

N yland NAMA Recovery, Massachusetts NAMA Recovery

N NAMA-R Advocates, S Jersey NAMA Recovery

N C NAMA Recovery, Advocates for Change (Syracuse)

R ode Island NAMA-R, Tennessee NAMA Recovery

V st Virginia NAMA Recovery, Wisconsin NAMA Recovery

International

A stralian IV League, HOPE (Bulgaria)

M a d'âme' (Canada), CRAMA (Croatia)

B rgerforeningen (Denmark), ACCES (France)

In ar Voice of Drug Users (India)

M hadone Indonesia, UISCE Ireland

I- CT (South Africa), Italy Gruppo SIMS, Recovering Nepal

L: delijk Steunpunt Druggebruikers (Netherlands)

L I ERATION (Poland), INTEGRATION (Romania)

S: nska BrukarForeningen (Sweden)

A: oc. Substitution Therapy Recelvers In Ukraine

M: hadone Alliance (UK), National Users Network (UK)

Projects

M: lication Assisted Recovery Support Project (MARS)

St o Stigma Now

Together, we can make a difference.

Health Services and Development Agency, 5/31/2013, page 2

not as a mood altering narcotic substitute. Also, like any chronic medical condition MAT is a corrective but not a curative regimen by holding brain function in a steady state.

Opiate addiction is a chronic relapsing medical condition. Abstinence oriented treatments are not effective and participants that leave these treatments are at high risk of relapse. The overwhelming evidence is that the majority of patients who leave MAT, irrespective of their type of discharge (favorable vs. unfavorable) and their individual prospects for successful abstinence, eventually relapse to daily use of narcotics. While successful treatment without medications might seem like a positive outcome it is in reality a dangerous one for the patient, their family and the community. Follow up studies of abstinent oriented therapies and medication therapies have been conducted for nearly four decades in the United States and numerous international countries. They confirm that today, persons who are HIV/HCV- and leave treatment are at high risk of contracting HIV/HCV after leaving treatment because of the high rate of relapse to drug use.

All forms of drug treatment bring significant savings to any community, but the greatest saving is in the cost of human lives. For every dollar spent on drug treatment the taxpayer is returned \$4 for every dollar spent. However when the various modalities are broken down a different picture appears: outpatient counseling returns \$4:1, residential treatment returns \$5:1 but MAT returns a \$15:1 for every dollar spent. This is because MAT patients are working and paying taxes unlike participants in residential programs, their children that may have been in foster care are returned to them and they become productive citizens contributing to the community.

The belief that OTPs increase crime is also unfounded and based on fear, ignorance and prejudice. Only 2 major studies have evaluated this (i.e. New York City and Hong Kong) and both found around a 35% drop in crimes rates. It can also be noted that similar decreases were found in public health indicators such as hepatitis infection rates. Other studies have evaluated MAT patients and found a significant drop in arrest rates. Individuals enter treatment whether it is abstinent oriented or MAT to change their lives for the better and for MAT these changes are significant.

There is also concern that the proposed clinic will be for profit. From our experience whether a clinic is for profit or non profit is irrelevant as some of the worst OTPs are non profit and two of the best OTPs in the US are for profit. What matters is the quality of care provided to the patient and OTPs are highly regulated at the federal and state levels that set standards for care and treatment. It is far better to have a for profit OTP than no treatment at all.

NAMA-R has no financial interest in the opening of an OTP in Johnson City. For the past twenty years when residents of this area have contacted us for assistance in finding treatment NAMA-R could only refer individuals to an clinic more than one hundred miles away. This is a severe hardship for anyone seeking help and many low income individuals cannot travel the distance thus making treatment impossible for them. To be able to say to a family in crisis "Yes you have an OTP right in Johnson City" we would look forward to.

Continued

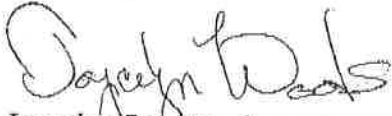
Together, we can make a difference.

Health Services and Development Agency, 5/31/2013, page 3

The community needs to realize that one option (i.e. abstinence) is not quality treatment. MAT is called the "Gold Standard" and the *standard of care* for opiate addiction just as insulin is for diabetes. Why then would the citizens of Johnson City not want the best treatment available and rather than opposition should be proud to have an OTP opening in their community as it will save the lives of many citizens.

Since its beginning methadone treatment has been demonstrated to be the most effective treatment for narcotic addiction, resulting in the termination of heroin use and of criminal behavior. In spite of this success, methadone treatment is often disparaged as a "substitute drug" by those who ignore the positive benefits that it has clearly brought to society. These attitudes negatively impact on opiate treatment programs in a variety of ways, but it is the methadone patients themselves who are particularly stigmatized and harmed. With the introduction of buprenorphine it was hoped that the public would gain a greater understanding of opiate addiction and its treatment. However, this has not occurred and rather than improving the situation buprenorphine patients experience the same discrimination and stigma as patients receiving methadone. The atmosphere will not change as long as there is no organization or formal mechanism for patients receiving Medication Assisted Treatment (MAT i.e. methadone and buprenorphine) to voice their own needs and to form a strong unified public presence on their own behalf. As the premier national advocacy organization for MAT the **National Alliance for Medication Assisted Recovery*** (NAMA Recovery) will actively respond to the issues that affect the daily lives of patients and work towards the day when they can take pride in their accomplishments.

Sincerely,



Joycelyn Sue Woods, M.A., CMA
Executive Director

Together, we can make a difference.

Tennessee Health Services and Development Agency
The Frost Building Third Floor
161 Rosa L. Parks Blvd.
Nashville, TN 37243

2013 MAR 26 AM 9: 28

March 12, 2013

Dear Members of the Review Board:

I am writing you to urge you to approve Tri-Cities Holding's Certificate of Need.

My father was a World War II veteran and came home with injuries suffered when his legs were crushed by a tank. As you can imagine, this was a very painful injury that required significant pain medicine for my dad. The consequence of the required pain medicine was the addiction that came with it. I watched my dad suffer through that addiction.

I understand that clinics such as Tri-Cities treat veterans who come home addicted to pain medicine. I can't help but think that my dad's life would have been better had this treatment been available to him.

In addition to my dad, I know other members of our community who became addicted to pain medications through their jobs and accidents. I believe that there are patients who go to these clinics, including veterans, who have become addicted to pain medication for legitimate reasons and need our help getting their lives back together. They should not have to drive 100 miles to Knoxville.

Sincerely,

Pete Adams
Johnson City, TN

June 13, 2013

2013 JUN 13 AM 9:16

Dear Mr. Farber

I am writing to you in regards to opening a clinic in Johnson City. I had hoped to be able to attend the meeting a few weeks ago, but unfortunately was unable to. I have a son who lives at home, is a full time college student, and a methadone clinic patient. As you are well aware, he must travel to Asheville daily for his treatment. My son was approximately 21 years old when he became addicted to opiates. It was a nightmare of any parent. I worried when he would leave the house, I worried when he would not come out of his bedroom, and I worried when he would. I would pace the floors praying he would make it back home safely when he would leave the house. His health suffered, the family suffered, due to his addiction. Then one day, he said to his father and me, I am going to get help. He had researched and found that the only clinic available to him was in Asheville. That was 9 months ago. He was down to about 120 pounds when he went, and is now up to nearly 180. His life has changed drastically....and for the better. He can now focus on classes, and be a functioning member of our family and society. His father makes the trip to Asheville with him every morning at around 4:00 a.m. The cost of gas and the treatment combined has put a tremendous financial hardship on our family. Just a few days ago, I had to refinance our home. The total expense for his treatment averages about \$700.00 a month. This cost would be reduced by more than half, if there was a clinic in Johnson City. I do not regret him going, under no circumstances, and if need be I would sell my home to allow him to continue his treatments. It was to the point I was afraid I would get a phone call from the Jail, or worse yet the Morgue. We lived a true nightmare until he found treatment in Asheville. He has been in the program since last October. I have my son back finally, thanks to the clinic. However, the opposition to this clinic be permitted in Johnson City just baffles the mind. I can not believe people are so closed minded, and ignorant to the need of having a clinic here. The cost of travelling to Asheville has placed a true hardship on our family, as I am sure it has hundreds of others. I implore you and anyone else who can assist with helping get this clinic approved to please, please do so. We have nothing to lose, and everything to gain, when we help those who need it. Please, please! Get this clinic in Johnson City as soon as possible!

Sincerely


Renzie L. Reed

173 East Highland Road

Johnson City Tennessee 37601

423-833-5235

renziel@aol.com

Robert G. Newman, M.D.

Director

The Baron Edmond de Rothschild
Chemical Dependency Institute of
Beth Israel Medical Center

April 8, 2013

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
The Frost Building Third Floor
161 Rosa L. Parks Blvd.
Nashville, TN 37243

Dear Ms. Hill:

This letter is submitted in support of the proposed opiate treatment program in Johnson City. I am Director of the Chemical Dependency Institute of Beth Israel Medical Center in New York. I received my medical degree from the University of Rochester School of Medicine and Dentistry, and subsequently earned my master's degree in public health from the University of California at Berkeley.

My background includes:

- more than 40 years of experience in the field of addiction and its treatment, most specifically treatment of opiate dependence with methadone;
- over 40 years of extensive interaction with opiate treatment providers throughout the United States and internationally;
- involvement with and advocacy for addiction treatment programs (specifically, programs utilizing methadone in the out-patient management of opiate dependence) in countries throughout the world (North America, Western and Eastern Europe, Central Asia, the Far East and Australia); and
- preparation for prior testimony in 3 cases involving strong community opposition to the establishment of opiate treatment programs in Antioch, California, Berwyn, Illinois, and Baltimore, Maryland.

I would urge you and your committee to consider the following facts with respect to opiate addiction and its treatment.

1. Opiate addiction is a chronic medical condition and for decades has been recognized as such by the most objective and respected authorities of the world, including the National Institute on Drug Abuse (NIDA) and the World Health Organization. Indeed, I attended a meeting in Florida this past week at which the Director of NIDA, Dr. Nora Volkow, reiterated a statement she has made repeatedly in the past: "Addiction is a disease of the brain."

2. While addiction is (to date) a medical condition for which no cure is known, it is one that can be treated and treated with very considerable efficacy.

3. No treatment of addiction has been the subject of more research and evaluation than methadone maintenance, and none has been associated with greater ability to assist patients to resume healthy, productive, socially acceptable lives.

4. The pharmacological properties of methadone when used in the treatment of opiate dependence are well established. Its long duration of action (24-36 hours) and predictable effect when taken orally allow it to be administered by mouth once a day, and constant dosage is associated with a degree of tolerance that precludes most of the actions experienced by non-tolerant individuals – including, among others, euphoria and central nervous system depression. This tolerance, which at appropriate dosage can be extremely high, prevents the effects not only of methadone itself but of all other medications in this class – i.e., all opiates, including heroin and the wide array of opiate pain-killers. In addition, daily administration of methadone causes elimination, or at the very least marked reduction, of the “craving” to which relapse to opiate abuse and misuse is generally attributed. In sum, far from providing a “substitute high,” methadone maintenance in appropriate doses **prevents** opiate-induced euphoria.

5. Federal and state laws and regulations demand strict adherence to treatment guidelines that call for comprehensive social services along with the medication that is administered and dispensed, and every program in the United States must meet myriad stringent standards imposed and monitored (through periodic unannounced inspections) by the same standard setting agencies that govern all health care facilities (e.g., the Joint Commission on Accreditation of Healthcare Services).

6. Although fear of negative impact on local neighborhoods is common when a methadone treatment facility is proposed for a specific neighborhood, I am aware of no study that has ever documented such a negative impact - either according to local crime statistics, real estate values, traffic incidents, etc. I have recently searched, once again, for reports of such data and found none.

7. Some of the clearest expressions of support for methadone clinics have come from individuals responsible or law enforcement. Thus, the Rutland (Vermont) Herald reported just a few weeks ago: “... comments from city Police Chief James Baker at a community meeting Wednesday. Baker has repeatedly said the clinic is badly needed in the city's fight against drug addiction. ‘I am appalled that we still don't have a methadone clinic here,’ Baker said Wednesday. ‘It's a proven fact that methadone helps people manage their lives.’” (<http://www.rutlandherald.com/article/20130309/NEWS01/703099904>)

8. It is my experience, over the course of more than four decades that patients receiving methadone treatment are, as a general rule, keenly sensitive to the need to maintain a low profile in the community and avoid activities that would arouse the anger of neighbors and thus threaten the continued viability of the facility that provides their treatment.

9. I have had direct responsibility for planning, directing and monitoring over 50 clinics that operated in diversified locations: residential as well as business neighborhoods, in an elementary school, a church and in a Wall Street office building, in hospitals and ambulatory health centers, and even on board a decommissioned Staten Island ferry boat. I have not been aware of any evidence of rise in criminality or other negative consequences that could be attributed to those treatment facilities.

10. It has been my consistent experience that the motivation of opiate dependent individuals to enter and remain in methadone treatment programs is as great or greater than that associated with any other illness. The willingness to adhere to rules such as hours of attendance, anti-loitering provisions etc. is further heightened by the fact that in almost every part of the country the demand for treatment far exceeds the capacity of existing programs;

unlike patients with virtually any other chronic illness, patients who want and need the assistance that methadone maintenance offers have no alternative sources of care if they are denied continued enrollment in "their" program.

11. The motivation of patients to be good neighbors is matched by the motivation of the owners/managers/staff of the programs providing this treatment.

12. There is no dichotomy between the interests of the staff, patients and general community where methadone maintenance treatment is concerned. To the contrary: providing care to opiate dependent individuals is known to be associated with markedly improved health status and social functioning (and sharply lower likelihood of death) for patients, while for the community it reduces criminality, risk of spread of communicable disease (including HIV-AIDS) through careless disposal of needles and unprotected sex, abandonment of family support responsibilities, etc.

13. The introduction in 2002 of buprenorphine for the management of opiate dependence deserves comment. Heralded as an important additional therapeutic tool in the treatment of addiction, it has both similarities and differences when compared to methadone. Buprenorphine is also an opiate, but it has both positive ("agonist") effects and negative ("antagonist"). It has no therapeutic benefits over methadone, and there is no evidence suggesting that **post-treatment** outcomes (i.e., persistent abstinence) differ between the two medications.

14. The regulatory conditions under which buprenorphine and methadone may be used differ. Thus, the stringent regulatory demands imposed on all methadone treatment facilities (see paragraph 5, above) do not apply to buprenorphine; the latter may be prescribed by any "certified" physician, in any practice setting, for pharmacy dispensing of a month's supply at a time, even upon the first office visit, and there are no requirements for provision or acceptance of any psychosocial supportive services, urine testing to monitor compliance, etc.

THE PROPOSED JOHNSON CITY, TENNESSEE PROGRAM:

I have seen no information that suggests to me any particular potential for deleterious impact on the local community that might be anticipated if the proposed treatment facility were to be implemented.

It is my opinion that methadone maintenance treatment facilities are in every sense medical care offices, and that their impact on local communities is no different than that of any other facilities offering medical care.

Sincerely,



Robert G. Newman, MD, MPH

AFFILIATION: Baron Edmond de Rothschild Chemical Dependency Institute of
Beth Israel Medical Center (Director)

NOTE: this statement was prepared and submitted *pro bono*. No compensation has been requested and none would be accepted if offered.

March 17, 2013
8564 Horton Hwy.
Greeneville, TN 37745

2013 MAR 21 AM 9:13

TO WHOM IT MAY CONCERN: I have worked with young people for over thirty years dealing with their educational, emotional, and physical everyday problems. For the majority of the young people I worked with, had used drugs or was using them on a daily basis to rid themselves of their physical and emotional pain.

Therefore, I firmly believe in a methadone clinic in the Johnson City area. We, the community, and the young people, would truly benefit from it conception.

Thank-you so much,


Rosana M. Beyer BS,MA

To whom it may concern,

Concerning the proposed methadone clinic in Johnson City.

I am in full support of it. Abstinence works in some people but not in others.

If you know you're going to get your daily dose you are more likely to be able to hold a job and live your life.

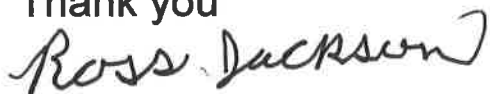
Prescription drug abuse is rampant in the area. Chasing that dose everyday is no fun.

Addiction knows no social or economic boundaries. It ranges from soccer moms to street junkies. No one wants to be a junkie and a clinic would provide them with a pathway to get clean without constantly trying to find drugs and come up with the money to buy them. That is where most of the crime comes in.

As far as crime around the clinic, that's what the police are for.

Please issue a certificate of need. The problems are just getting worse.

Thank you

A handwritten signature in cursive script that reads "Ross Jackson".

Ross Jackson
PO Box 185
Chuckey, TN 37641

FW: Support of Johnson City, TN Methadone treatment center.

Melanie Hill

Sent: Monday, May 13, 2013 11:51 AM

To: Kathleen Edwards; Melissa Bobbitt; Phillip M. Earhart; Mark Farber; Jim Christoffersen

Melanie

Melanie M. Hill, Executive Director
Health Services & Development Agency

melanie.hill@tn.gov

615-741-2364-phone

615-741-9884-fax

www.tn.gov/hsda

From: Tia Johnson [tiastarjonson@gmail.com]

Sent: Friday, May 10, 2013 9:19 PM

To: Melanie Hill

Subject: Support of Johnson City, TN Methadone treatment center.

I would like to express my total support for the proposed MMT center in Johnson City, TN. I can't imagine a persons opposition being fact based, probably based solely on myths and personal emotions. I have personally experienced the benefits of this type of treatment.

Tonya Baldwin Worley
809 Ashley Lane
Hendersonville, NC 28792
May 18, 2013

Tennessee State Health Services and Development Agency
The Frost Building, 3rd Floor
161 Rosa L. Parks Blvd.
Nashville, TN 37243

To Whom It May Concern:

I am writing to ask that you (and all parties and committees involved) please take into consideration my impassioned plea in support of the opening and operation of the proposed Medication Assisted/Methadone Maintenance Treatment Clinic/Facility in Johnson City, TN.

The main purpose of this Clinic/Facility would be to implement and offer the opiate addicted person the most tried and true, clinically sound/evidence based modality of treatment/recovery known to date for their disease of addiction. Methadone Maintenance has over 40 years of evidence of success and, in addition to helping the Opiate addicted person, in turn, it will allow and afford Johnson City (and any of the surrounding cities/counties) benefit and award to include, but not limited to, a returned citizen with improved health and well being that will benefit the community, their family and society as a whole rather than hinder/harm it.

Communities that allow and encourage Medication Assisted/Methadone Maintenance Treatment (hereinafter referred to as MMT/MAT) note and experience a remarkable reduction in drug related crime rates, to include arrest and incarceration cost and a visible improvement in their unemployment rates. A decrease in HIV and HCV related illnesses (from IV Drug use) and deaths from Suicide and Overdose.

Tennessee is in great need for MMT/MAT. **In recent findings there exist facts evidencing that Tennessee prescribes/dispenses more opiates, has one of the largest Opioid addicted affected populations and more overdose deaths in comparisons to most other States per capita.** What more would be needed in support of the proposed clinic? To resist such would be blatant disregard for the betterment and/or resolve of and for the State, the community and the people.

I strongly encourage Johnson City, the County of Washington and the State of Tennessee to look beyond and even past the "stigma and discriminations" of MMT/MAT as much of the information behind them are just rumors and allegations (unfounded and untrue) to create a division of the people so the NIMBYism (not in my backyard) can prevail.

People/Community want the results that treatment has to offer but some do not want to provide the place and/or opportunity for it to exist in Fear of the unfounded and untrue

Tennessee State Health Services and Development Agency

May 19, 2013

Page 2

implications that a clinic in their community would be a “pimple” or “dark spot”. Well in favor of MMT/MAT and in defense against NIMBYism, Clinics do not harm people, communities and/or “backyards”. In fact evidence shows the opposite in that Clinics will improve said areas if granted the **opportunity and place**. I am asking that Johnson City, Washington County and the State of Tennessee to please grant “the place” to allow “the opportunities” for “the people” (some addicted but many affected).

Thank you for allowing me this MUCH NEEDED VOICE in support of MMT/MAT and the opening of this MUCH NEEDED CLINIC.

Sincerely,

Tonya B. Worley

Zachary C. Talbott | Director
NAMA Recovery of Tennessee
www.methadone.org
4522 Rocky Branch Rd
Walland, Tennessee 37886
865-982-4048
tndirector@methadone.org

2013 APR 17 AM 9:14

April 11, 2013

Tennessee State Health Services and Development Agency
The Frost Building, 3rd Floor
161 Rosa L. Parks Blvd.
Nashville, TN 37243

To Whom It May Concern:

I am writing to your office in SUPPORT of the proposed medication assisted/methadone maintenance treatment center/clinic in Johnson City, Tennessee. I support the opening of a medication assisted/methadone maintenance treatment center/clinic forthwith because...

- Eastern Tennessee probably has more untreated opioid addicts per acre than anywhere else in the nation. Tennessee has the 13th highest opioid overdose deaths per capita, compared to all other states, and is ranked number TWO in the kilogram of opioids prescribed per capita (http://cdc.gov/mmwr/preview/mmwrhtml/mm6c4s_cid+mm6043a4_w).
- The treatment of opioid addiction with methadone is one of the most strongly evidence-based medical treatments in all of medicine.
- There are over 40 years of studies that show the treatment of opioid addiction with methadone reduces overdose death rates and suicide rates.
- Methadone treatment improves employment rates and dramatically reduces crime rates.
- Addicted people treated with methadone have improved physical and mental health.
- For each dollar spent on methadone treatment, taxpayers saved four dollars, mostly in reduced incarceration costs.
- Methadone treatment of opioid addiction significantly reduces the incidence of HIV and HCV in intravenous opioid addicts.

I STRONGLY encourage Tennessee state, Washington County and Johnson City officials to act on this chance to save lives and put aside personal biases and look at the science supporting medication assisted treatments. It's the right thing to do.

Sincerely yours,



Zac Talbott

CC: Washington County, Tennessee Commission
CC: Johnson City, Tennessee City Council

231 Sand Valley Rd.
Jonesborough, TN. 37659
June 17, 2013

Tenn. Health Services & Development Agency
Frost Building Third Floor
161 Rosa Parks Blvd.
Nashville, Tn. 37243
Attn: Mark Farber

Dear Mr. Farber.

I am writing to voice my objections to having a Methadone Clinic in the Johnson City area or anywhere for that matter. Methadone is not a treatment! It is highly addictive and nothing more than a replacement for some other drug that the addict has been using. Methadone is supplied to the clinics by the government at tax payer expense. The addict is also charged for the methadone. No counseling is provided. We have legitimate treatment centers in this area for those that truly want to receive treatment. And no one wants a bunch of addicts coming into their neighborhood on a daily basis. The crime rate would escalate and people would fear for the safety of their children.

The group that wants to establish a Methadone Clinic in this area has no other interest than to make money at the expense of the community. The drug problem in this area is really bad and the government needs to find a solution to the problem, not create another one.

Thank you for your time.

Sincerely

Aloha Jean Feather, R.N.

Aloha Jean Feather, RN
1-423-753-9127

cc: Johnson City Press